

4780

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Rural		LENGTH OF STAY (in this place) 1 mo 6 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dumfries 83X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 83 Tripoli Heights			
3. NAME OF DECEASED: (First) Ralph (Middle) Douglas (Last) ADAMS				4. DATE (Month) (Day) (Year) OF DEATH: May 19 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 3-17-55	9. AGE last birthday yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	Hours 2 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Ray F. ADAMS				14. MOTHER'S MAIDEN NAME: Margaret A. TANKESLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Father Capt Ray F. ADAMS USMC Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 7544 Congestive failure						1 month	
ANTECEDENT CAUSE (B) Due to Congenital Heart Disease (Transposition of great vessels, IV septal defect, patent ductus + coarctation of aorta)						2 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 13 Apr, 1955 , to 19 May, 1955 , that I last saw the deceased alive on 19 May 1955 , and that death occurred at 4:10 AM , from the causes and on the date stated above.							
SIGNATURE D. J. PASCOE				DATE SIGNED			
D. J. PASCOE LT MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 23 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 19 May 1955		REGISTRAR'S SIGNATURE Mary E. Casselley		24. FUNERAL DIRECTOR Chambers Funeral Home		ADDRESS 3072 M Street, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4750 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 21 Film G182 5-27-55 am

CERTIFICATE OF DEATH

Reg. Dist. No. 114751 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Takoma Park</u>		<u>11 days</u>		OR TOWN <u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hosp.</u>				STREET ADDRESS (If rural give location) <u>8027 Glenside Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Barbara Jane Amerman</u>				<u>May 14 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>married</u>	<u>June 10, 1911</u>	<u>43</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Personnel Natl. Labor Relations Board</u>		<u>Kansas</u>		<u>USA.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William F. Lindley</u>				<u>Alice Heller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>Washington Sanitarium & Hospital Records.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary embolus</u>						<u>1/2 hour.</u>	
ANTECEDENT CAUSE (B) <u>General thrombophlebitis, right femoral</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Trauma to right leg, minor</u>						<u>about 21 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour)	
<input checked="" type="checkbox"/>		<u>Home</u>		<u>Takoma Park</u>		<u>15</u> (County) (State) <u>Md</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>Her dog struck leg, bruising it.</u>					
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work					
<u>Apr. 23 1955</u> M.							
22. I hereby certify that I attended the deceased from <u>JULY, 1954</u> , to <u>14 MAY, 1955</u> , that I last saw the deceased alive on <u>13 MAY, 1955</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel T. Kemble</u>				DATE SIGNED <u>14 May '55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 18, 1955</u>		<u>Arlington Hall Cemetery</u>		<u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FURNERAL DIRECTOR		ADDRESS	
<u>May-14-1955</u>		<u>William Rodd</u>		<u>254 CARROLL ST. N.W.</u>		<u>TAKOMA PARK, D.C.</u>	

COMMUNICATIONS SECTION

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4781

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Silver Spring</u>		<u>20 A.</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2023 Luzerne Avenue</u>				STREET ADDRESS (If rural, give location) <u>2021 Luzerne Avenue</u>			
3. NAME OF DECEASED:		(First) <u>William</u>		(Middle) <u>Russell</u>		(Last) <u>Antrim</u>	
(Type or Print)						4. DATE OF DEATH	
						May 30 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>5/20/93</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Printer - Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Govt. Printing Office</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Antrim</u>				14. MOTHER'S MAIDEN NAME: <u>Carolyn Rummell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Mrs. Laura B. Antrim, 2021 Luzerne Ave. Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION				Silver Spring, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Coronary occlusion</u>				<u>Sudden</u>			
DUE TO				<u>death</u>			
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Brerhart</u>		M. D.		ASSISTANT MEDICAL EXAM.		<u>5-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>6/2/55</u>		REGISTRAR'S SIGNATURE <u>Hances Potter</u>		24. FUNERAL DIRECTOR <u>Wanner & Humphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

9 NOV 1955

RECEIVED

4782

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Falls Church 83X-3			
X TOWN Bethesda Rural		2 days		STREET ADDRESS (If rural give location) 2128 Arlington Boulevard ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Thomas Preston APPLEBY				May 21 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single		8. DATE OF BIRTH: 19 May 1955	
				9. AGE last birthday: 2 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland	
13. FATHER'S NAME: Dan P. APPLEBY				14. MOTHER'S MAIDEN NAME: Joan SIMARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service) - -				16. SOCIAL SECURITY No. - -		17. INFORMANT'S ADDRESS: Father LCDR Dan P. APPLEBY USN Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Atelectasis, Congenital						2 days	
ANTECEDENT CAUSE (B) Prematurity						2 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 May, 1955 , to 21 May, 1955 , that I last saw the deceased alive on 21 May 1955 and that death occurred at 8:15AM , from the causes and on the date stated above.							
SIGNATURE M. S. Allen				ADDRESS DATE SIGNED			
M. S. ALLEN LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		24 May 1955		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
23 May 1955		Mary E. Garrelly		R. A. Pumphrey Funeral Home		7557 Wisconsin Ave. Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 26 1955

RECEIVED

4783

04754

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Geithsburg</u>		RURAL LENGTH OF STAY (in this place) <u>15 yrs</u>		CITY (If outside corporate limits write TOWN and give nearest town) <u>Geithsburg (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Pleasant Ave</u>				STREET ADDRESS (If rural, give location) <u>Mt Pleasant Ave</u>			
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>Berri</u> (Last) <u>Arnold</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>10-29-1867</u>	
9. AGE last birthday: <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>R. Berri Arnold</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>HA English - same as John 2</u>		17. INFORMANT & ADDRESS: <u>HA English - same as John 2</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO							<u>Found dead in bed</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochant</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>5-28-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>May 31 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Darkland</u>		LOCATION (City, town, or county) (State) <u>Brookville Pike</u>	
DATE REC'D BY LOCAL REG. <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Archie Cook</u>		24. FUNERAL DIRECTOR <u>Ray W. Barker</u>		ADDRESS <u>1127</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1953

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04755

4784

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Georgia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>5 weeks</u>		<u>Macon</u> <u>47x</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>143 Rogers Avenue</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Bonnie Sue AWIREY</u>				<u>May 28 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>10-10-04</u>	
9. AGE last birthday				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<u>50 yrs.</u>				<u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>Housewife</u>		<u>Georgia</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Franklin C. DAVIS</u>				<u>Susan CLEVELAND</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>None</u>		<u>2633 15th Street, N.W. Hugh R. Awtrey Washington, D. C.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO							
<u>581.0</u> <u>Cirrhosis of the Liver</u>						<u>1 year</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-24-</u> , 1955, to <u>5-28-55</u> , 19 ..., that I last saw the deceased alive on <u>28 May</u> , 1955, and that death occurred at <u>1135am</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. I. Plitman</u>				ADDRESS <u>U.S. Naval Hospital, NMC, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR'S ADDRESS			
<u>Removal Burial</u>				<u>Funeral Home</u>			
<u>1 June 1955</u>				<u>7551 Wisconsin Avenue, Bethesda, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>28 June 1955</u>				REGISTRAR'S SIGNATURE <u>Dr. E. C. Parrelly</u>			

BOULEVARD 1 S

1955

4785

04756
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Brookville</u>		RURAL <input checked="" type="checkbox"/> LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Brookville</u>		RURAL <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD - Box 129</u>				STREET ADDRESS (If rural, give location) <u>RFD</u>			
3. NAME OF DECEASED: (First) <u>Edwin</u> (Middle) <u>Ballinger</u> (Last) <u>Ballinger</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 8 1891</u>	
9. AGE last birthday: <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>P. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Ballinger</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>1-20</u>		17. INFORMANT & ADDRESS: <u>Mabel A. Ballinger (wife) Brookville MD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>20.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)							<u>sudden death</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>burial</u>		DATE THEREOF <u>May 25-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Crookston Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montg - new jersey</u>	
DATE REC'D BY LOCAL REG. <u>May 27-55</u>		REGISTRAR'S SIGNATURE <u>Antoine B. Gower</u>		24. FUNERAL DIRECTOR <u>Antoine B. Gower</u>		ADDRESS <u>Antoine B. Gower</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. S.

MAY

1905

4786

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>17 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Roanoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>1916 Canterbury Road</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Roy</u>	(Middle) <u>Franklin</u>	(Last) <u>Barnes</u>	OF DEATH: <u>May 22 19 55</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 12, 1910</u>
9. AGE last birthday <u>45</u> yrs.		10. IF UNDER 1 YEAR: <u>3</u> Months <u>10</u> Days	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ben Barnes</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Smitherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>234-07-1624</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
231X IMMEDIATE CAUSE (A) <u>Respiratory failure</u>			
ANTECEDENT CAUSE (B) <u>Primary tumor of left lung</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2--</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) INJURY OCCUR? <u>--</u> (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 5</u> , 1955, to <u>May 22</u> , 1955, that I last saw the deceased alive on <u>May 22</u> , 1955, and that death occurred at <u>8:25p M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-23-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Forestlawn</u>		LOCATION (City, town, or county) (State) <u>Logan Co., W. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 22 1907

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4787 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804758

CERTIFICATE OF DEATH

Reg. Dist. No.

216

Item 1, Film G131, 5/11/55

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u> ✓		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u> 56			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6412 Western Ave.</u>				STREET ADDRESS (If rural give location) <u>6412 Western Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Katie</u> <u>Bauer</u>				OF DEATH: <u>May 5, 1955</u>			
5. SEX. <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH. <u>Oct. 18, 1869</u>	
9. AGE last birthday: <u>85</u> yrs.		10. MONTHS <u>5</u>		11. DAYS <u>5</u>		12. HOURS <u>5</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Nicholas Steinmacher</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Anna Horner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Paul Edgar Bauer - Son</u> <u>7502 Vale Street, Chevy Chase, Md.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Uremia</u>				<u>48h</u>			
ANTECEDENT CAUSE (S) (B) <u>Hypertensive Cardio Vascular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Renal Disease</u>				<u>10y</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>1-17</u> , 19 <u>40</u> , to <u>5-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>55</u> , and that death occurred at <u>1:36 P</u> M. from the causes and on the date stated above.							
SIGNATURE <u>W. Flint Rickett</u>				ADDRESS <u>5000 Rm Rd 17A</u> DATE SIGNED <u>5-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>5/7/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>				LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
24. FUNERAL DIRECTOR <u>The S. W. Hines Co.</u>				ADDRESS <u>2901 14th St., N.W.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4751
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04759

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>2 1/2 yrs</u>		TOWN <u>Takoma Park</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Pine Ave</u>				STREET ADDRESS (If rural, give location) <u>17 Pine Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lewis</u> <u>Linwood</u> <u>Beasley</u>				<u>May</u> <u>21</u> <u>1955</u>			
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>11-29-1918</u>	
9. AGE last birthday: <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Int. Revenue</u>		11. BIRTHPLACE (State or foreign country): <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Woodruff T. Beasley</u>			
14. MOTHER'S MAIDEN NAME: <u>Beel Dery</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>1-29-18</u>				17. INFORMANT & ADDRESS: <u>Crestwood Nursing Home residents</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u>						Sudden death	
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-21-55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Br. Hea.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>May 21, 1955</u>		REGISTRAR'S SIGNATURE <u>J. W. M. Dodd</u>		24. FUNERAL DIRECTOR <u>A. J. Lipe Co.</u>		ADDRESS <u>4400 E. 2901 14th St NW</u>	

RECEIVED

MAY 19 1975

U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 414, 1116 101-5-20 55C

4776

03762
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>507 Woodston Rd.</u>				STREET ADDRESS (If rural, give location) <u>507 Woodston Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>JEFFERSON C. BEEKER</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3-25-15</u>	9. AGE last birthday: <u>40</u> yrs. <u>1</u> Months <u>7</u> Days <u></u> Hours <u></u> Min.		10. AGE last birthday: <u>40</u> yrs. <u>1</u> Months <u>7</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Thomas J. Beeker</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Leonard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>yes</u>		17. INFORMANT & ADDRESS: <u>Cleo L. Beeker- Item # 2</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							Interval Between Onset and Death <u>Sudden death</u>
Immediate cause (a) <u>Coronary occlusion</u> DUE TO							
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D. <u>5-3-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REG. <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Beagles</u>		24. FUNERAL DIRECTOR <u>Robert H. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

J.V.S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4788

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04760

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>Bethesda</u>	<u>2 hours</u>	<u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>74 Suburban</u>		<u>2570 Kimberly St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Bett Walter Edward Belt</u>		<u>May 12 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 12, 1900</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.
<u>Foreman</u>		<u>Telephone Co</u>	<u>54 yrs.</u>
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>District of Columbia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Robert E. Belt</u>		<u>Katherine Aloxman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>			
17. INFORMANT & ADDRESS:			
<u>J. William Belt. 3059 Oliver NW</u>		<u>Washington</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage - Rente</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis; generalized</u>			<u>yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral Fertilization</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Angina Pectoris</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>None</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/12/55</u> , 19... to <u>4/12/55</u> , 19..., that I last saw the deceased alive on <u>4/12/55</u> , 19..., and that death occurred at <u>10:02 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Samuel Allen</u>		ADDRESS <u>M. D. Kersington, Md.</u> DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Washington National Cemetery</u>	
DATE THEREOF <u>5/16/55</u>		LOCATION (City, town, or county) (State)	
		<u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>5/17/55</u>		<u>Bessie M. Thompson</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

MA 15

RECEIVED

4752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wolfgang</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wolfgang</u>	STATE <u>MD</u> COUNTY <u>Now</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wolfgang</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wolfgang</u>	LENGTH OF STAY (In this place)	STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Emily L. Wolfgang</u>		OF DEATH <u>21</u> <u>7</u> 19 <u>55</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: <u>Dec 22, 1917</u>
9. AGE last birthday <u>37</u> YRS		10. MONTHS <u>7</u> DAYS <u>1</u> HOURS <u>1</u> MIN.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Public Stenographer</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>Self</u>	
13. BIRTHPLACE (State or foreign country): <u>Arkansas</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME: <u>Wm. H. Benton</u>		16. MOTHER'S MAIDEN NAME: <u>Mary F. Worthington</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2. IMMEDIATE CAUSE	
<u>450.0</u>		<u>Cardiac Decompensation</u>	
3. ANTECEDENT CAUSE (S)		4. DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		<u>Atherosclerosis</u>	
5. DUE TO		<u>Bronchopneumonia</u>	
6. DUE TO		<u>Septic</u>	
7. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH.		8. <u>Septic</u>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>23 May, 1955</u> , that I last saw the deceased alive on <u>22 May, 1955</u> , and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William D. Cuff</u>		DATE SIGNED <u>5/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>4-23-55</u>	
NAME OF CEMETERY OR CREMATORY <u>DePauline Home</u>		LOCATION (City, town, or county) (State) <u>Wolfgang, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 23, 1955</u>		24. FUNERAL DIRECTOR <u>H. E. Kautz</u>	
REGISTRAR'S SIGNATURE <u>Francis Potter</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Emily Virginia Benton
Burial

May 24, 1955

Mt. Comfort Cemetery
Fairfax Cty, Va

Funeral Director

Wm Demain & Sons
Alexandria Va

RECEIVED
MAY 24 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04762
4789 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u># 109 Quincy Street</u>				STREET ADDRESS (If rural give location) <u># 109 Quincy Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>MARGARET ALICIA BINGHAM</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 2, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>7-4-1878</u>	
				9. AGE last birthday: <u>76</u> yrs. <u>9</u> Months <u>28</u> Days <u>8</u> Hours <u></u> Min.			
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Wash. DC</u>	
13. FATHER'S NAME: <u>John McDonald</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Keohane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Julia A McDonald, 5607 Brookville, Md</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> Immediate cause (a) ... <u>Cerebrovascular</u> DUE TO Antecedent causes (s) (b) ... <u>Sclerosis</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>✓</u>				19b. MAJOR FINDINGS OF OPERATION: <u>✓</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		CITY OR TOWN <u>Chevy Chase, Maryland</u>		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 15, 1955</u> , to <u>May 2, 1955</u> , that I last saw the deceased alive on <u>May 2, 1955</u> , and that death occurred at <u>5:10 PM</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> (Degree or title) ADDRESS <u>3800 Oak Ave. N.W. Wash. D.C.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-5-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons</u> ADDRESS <u>1756 Pa. Ave. N.W. Washington, D. C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 6 1915

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

4790

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

04763

No. 218

1. PLACE OF DEATH:

COUNTY

MONTGOMERY

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN

STREET ADDRESS

(If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

4. DATE OF DEATH

(Month)

(Day)

(Year)

5

1

1955

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

M. D.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS



4791

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>36 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4111 54th St.</u>			
3. NAME OF DECEASED: (First) <u>Theresa</u>		(Middle) <u>P.</u>		(Last) <u>Blaine</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>10</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>24 Apr. 1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Mln. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry S. Preston</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Larson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of breast with metastases to liver</u>							
DUE TO <u>lungs, brain, bones & multiple lymph nodes</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1955</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>8:35AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James A. Pittman</u>				DATE SIGNED <u>May 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Sec. Wash. Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Prince Geo County MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W.W. Chamber</u>		ADDRESS <u>Co. 1400 Chapin St</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 19

4792

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY <u>Alexandria</u>
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>21 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Alexandria</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>3124 Martha Custis Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Victoria Theresa Bogusky</u>		4. DATE (Month) (Day) (Year) OF DEATH. <u>May 18 19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>18 April 1915</u>
9. AGE last birthday <u>40</u> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Alexander Michinski</u>		14. MOTHER'S MAIDEN NAME: <u>Stella Kuznicki</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
754.1 IMMEDIATE CAUSE Rupture of pulmonary artery with massive hemorrhage at operation for ligation of patent ductus arteriosus.			
ANTECEDENT CAUSE (S) Patent ductus arteriosus with reversal of flow.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (c) Dilatation of atherosclerotic pulmonary artery.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>May 18, 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>Patent ductus arteriosus with reversal of flow and dilatation of atherosclerotic pulmonary artery.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID INJURY OCCUR? <u>None</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 27, 1955</u> , to <u>May 18, 1955</u> that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>3:20P M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. D. Marrow</u>		DATE SIGNED <u>May 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		NAME OF CEMETERY OR CREMATORY <u>The Clinical Center</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Fitzgerald Funeral Home</u>		ADDRESS <u>3845 Wilson Rd. Arlington Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.

4793

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Potomac</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Potomac</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Rt. #3 Box 126 Bethesda, Md.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ALICE EMMA BONIFANT</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 19, 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>12-25-63</u>
9. AGE last birthday <u>91</u> yrs		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>24</u> Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Montg. Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>James Bonifant</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Craigen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Florence Bonifant-Item # 2</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE <u>Coronary Arteriosclerosis</u>		<u>1 DAY</u>	
(B) ANTECEDENT CAUSE (S) <u>Coronary Arteriosclerosis</u>		<u>10 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis (hypertrophic atherosclerosis)</u>			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/6, 1944</u> to <u>5/19, 1955</u> , that I last saw the deceased alive on <u>5/18, 1955</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>5/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-21-55</u>	<u>Potomac Cemetery</u>	<u>Potomac, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	ADDRESS	
<u>5/23/55</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Humphrey Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 20 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04767

4794

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville - rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville - rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Boswell Lane - rural - RD#2		STREET ADDRESS (If rural, give location) Boswell Lane - R. F. D. #2	
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) M.	(Last) BOSWELL, Sr.
4. DATE OF DEATH	(Month) May	(Day) 28	(Year) 1955
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8/15/1882
9. AGE last birthday 73 yrs.		10. UNDER 1 year 2 Months	11. UNDER 24 hrs. 13 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-empl.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles E. Boswell	
14. MOTHER'S MAIDEN NAME Mary catherine Melbrook		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Martha C. Boswell- Same Item #2	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carcinoma of Liver			2 years
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec , 19 54 , to 28 May , 19 55 , that I last saw the deceased alive on 27 May , 19 55 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
SIGNATURE W. S. Murphy, M.D.		ADDRESS Rockville, Md. DATE SIGNED 28 May 55	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/30/1955	Darnestown Presby	Montgomery Co. Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/31/55	James H. Hayslop	Robert R. Humphrey	Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

04768

2411 N. Charles Street, Baltimore

4795

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RFD Laurel Maryland</u>	
TOWN <u>Burtonsville</u>		TOWN <u>Burtonsville</u>	
HOSPITAL, INSTITUTION OR STREET ADDRESS <u>Doran Street</u>		STREET ADDRESS <u>Doran Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>SIMON</u> (Middle) <u>FRANKLIN</u> (Last) <u>BOWERSSETT</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Mar 23, 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Byrd Bowersett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elsie Ramey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-1786</u>	
17. INFORMANT AND ADDRESS <u>son - Charles Bowersett - same address</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
446X Immediate cause (a) <u>uremic syndrome</u>		<u>2 weeks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>kidney failure</u>		<u>1 year</u>
(c) <u>arteriosclerosis</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan, 1955, to 9 May, 1955, that I last saw the deceased alive on 9 May, 1955, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE John R. Buell MD (Degree or title) ADDRESS 402 Main St Laurel Maryland DATE SIGNED 9 May 55

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>	LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 1955</u>	REGISTRAR'S SIGNATURE <u>Francis J. [illegible]</u>	24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u>	ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. DUNNAN

MAY 19

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04769
4753 CERTIFICATE OF DEATH Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sant Hosp.</u>				STREET ADDRESS (If rural give location) <u>1206 Hemlock St. NW.</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Franklin</u> (Last) <u>Brandt</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> - <u>5</u> - <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>married</u>	8. DATE OF BIRTH: <u>7-31-98</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR: Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Kleen Kut Sales & Serv.</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Simon Brandt</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Conkle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hosp. Records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Rupture of Heart and Aorta pericardium</u>				<u>5/5/55</u>			
ANTECEDENT CAUSE (B) <u>Myocardial Infarction</u>				<u>5/1/55</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Occlusion</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart Failure</u>							
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24</u> , 19 <u>55</u> , to <u>5/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/5</u> , 19 <u>55</u> , and that death occurred at <u>7:55 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Snow</u>		M. D. <u>Takoma Park</u>		DATE SIGNED <u>5/5/55</u>			
23. BURIAL, CREMATION, REMOVAL SPECIFY <u>Transit - Brandt</u>		DATE THEREOF <u>5-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Canton</u>		(State) <u>Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 6 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Snow</u>		24. FUNERAL DIRECTOR <u>Wm. S. H. Harris</u>		ADDRESS <u>2801-14th St. NW Wash. D.C.</u>	

11/11

11/11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04770

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>D.C.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12,304 Dewey Road</u>				STREET ADDRESS (If rural, give location) <u>2727 N St., S.E.</u>			
3. NAME OF DECEASED (First) <u>Theodore</u>		(Middle)		(Last) <u>Broderick, Sr.</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 29, 1867</u>		9. AGE last birthday <u>87</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher - retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Pat (Daniel) Broderick</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Engel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-20-3114</u>		17. INFORMANT AND ADDRESS <u>Mr. Theodore Broderick, Jr.</u>	
18. MEDICAL CERTIFICATION <u>12,304 Dewey Rd., Silver Spring, Md.</u>							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> Interval between Onset and Death <u>sudden death</u> Antecedent cause(s) (b) <u> </u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, or office hldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broderick</u>				ADDRESS <u>Lanham, Md.</u>		DATE SIGNED <u>5-28-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Trans. & Burial</u>		DATE THEREOF <u>5/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
DATE REC'D BY LOCAL REG <u>5/28/55</u>		REGISTRAR'S SIGNATURE <u> </u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

S. A. -

1955

4797 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04771

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Olney</u> TOWN <u>Olney</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Rockville</u> STREET ADDRESS (If rural give location) <u>Route 1</u>			
3. NAME OF DECEASED: (First) <u>Michael</u> (Middle) <u>Eugene</u> (Last) <u>Butt</u> (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>8</u> <u>19</u> <u>55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>5/8/55</u>	
9. AGE last birthday: <u>yr.</u> <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u> <u>10</u> <u>49</u>				10. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Newborn</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Sidney Eugene Butt</u>				14. MOTHER'S MAIDEN NAME: <u>Janice Lorraine Connolly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mother</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>762.5</u> <u>Atelectasis (hyaline membrane?)</u>						<u>11 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Prematurity (7 1/2 months - 5 lb 2 oz)</u>						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION: <u>0</u>						19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 8, 1955</u> to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 8, 1955</u> , and that death occurred <u>at 10:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>J. M. L. Lanthorn</u>				ADDRESS <u>Rockville, Md.</u> DATE SIGNED <u>5/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-10-55</u>		NAME OF CEMETERY OR CREMATOR <u>Darnatown Presbyterian Church</u>		LOCATION (City, town, or county) (State) <u>Darnatown Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-9-55</u>		REGISTRAR'S SIGNATURE <u>Esther B. Lawler</u>		24. FUNERAL DIRECTOR <u>Robert W. Thompson</u>		ADDRESS <u>Darnatown, Md.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOHANN A. S.

MAY 11 1945

RECEIVED
MAY 11 1945

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4798

CERTIFICATE OF DEATH

Reg. Dist. No.

04772

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		4530 Avondale St., Apt. # 8		STREET ADDRESS (If rural give location)		4530 Avondale St., Apt. # 3	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
MARY ANN FRANCES CARLIN				May 11 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	Feb. 20, 1870	85 yrs	2 Months	21 Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Own Home		New Jersey	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James Cordock				Elizabeth Denin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No.				None		Mr Jos. M. Cohan- Item # 2	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION						24 HOURS	
ANTECEDENT CAUSE (B) CORONARY THROMBOSIS							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ARTERIOSCLEROSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from alive or MAY 11, 1955, and that death occurred at 27 M, from the causes and on the date stated above.				DATE SIGNED			
SIGNATURE				ADDRESS			
St. Raymond S. Harvath				1501 West N.W. WASH. DC. 5-12-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial-Transit		5-13-55		St. Raymonds-New York		New York, Bronx N.Y.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5/12/55		Beaumont Thompson		Robert A. Jumper		Bethesda, Md.	

3 A 100

4799

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) <u>Silver Spring</u>	(in this place) <u>3 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1507 East West Highway</u>		STREET ADDRESS (If rural give location) <u>1507 East West Highway</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Robert</u>	(Middle) <u>Miller</u>	(Last) <u>Carnahan</u>	(Month) <u>May</u> (Day) <u>1</u> (Year) <u>1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>6 Sept 1880</u>
		9. AGE last birthday: <u>74</u> yrs.	10. AGE last birthday: <u>74</u> yrs. (Months) <u>0</u> (Days) <u>0</u> (Hours) <u>0</u> (Min.)
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Master Mechanic U.S. Naval Gun Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Scotland</u>	
11. BIRTHPLACE (State or foreign country): <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Alexander Carnahan</u>		14. MOTHER'S MAIDEN NAME: <u>Grace McWhir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Margaret Goshirk Carnahan (wife) 1507 E. W. Hwy</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
420.2 Immediate cause (a) <u>Asphyxia</u>		<u>48 hrs</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>acute cardiac dilatation</u>		<u>48 hrs</u>	
(c) <u>cardiovascular renal disease with hypertension, decompensation, angina</u>		<u>one year</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1926</u> to <u>1 May</u> , 1955, that I last saw the deceased alive on <u>1 May</u> , 1955, and that death occurred at <u>9:40</u> , from the causes and on the date stated above.			
SIGNATURE <u>James Drathingly, M.D.</u>		DATE SIGNED <u>1 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> DATE THEREOF <u>5/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>2200 R.I. Ave N.E. Wash. D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter Warner & Humphrey</u>	
24. FUNERAL DIRECTOR <u>8434 Georgia Ave. Silver Spring, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. V. S.

1955

PAID

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4800 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 04774

Item 11: film G182 6-2-55 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural - Kensington</u> LENGTH OF STAY (in this place) <u>4 months</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3000 McComus Ave.,</u>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural - 4317 Saul Road</u> STREET ADDRESS (If rural give location) <u>Kensington</u>	
3 NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Frederic Webster Case</u> 5. SEX: <u>male</u> 6. COLOR OR RACE: <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u> 8. DATE OF BIRTH: <u>October 11, 1904</u> 9. AGE last birthday: <u>50</u> yrs. <u>7</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.		DEATH: <u>May 21 1955</u> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Builder</u> 10B. KIND OF BUSINESS OR INDUSTRY: <u>Real Estate</u> 11. BIRTHPLACE (State or foreign country): <u>California</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Lewis Frederic Case</u>		14. MOTHER'S MAIDEN NAME: <u>Lena Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS: <u>Mrs. Frederic Case, 4317 Saul Road Kensington, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Probable Pulmonary embolus</u> ANTECEDENT CAUSE (B) <u>Arteriosclerosis; hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Glomerulonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>18 yrs</u> <u>18 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 2, 1954, to May 21, 1955, that I last saw the deceased alive on May 19, 1955, and that death occurred at 8:10 P.M. from the causes and on the date stated above.			
SIGNATURE <u>Katharine A. Chapman</u>		DATE SIGNED <u>May 21, 1955</u>	
ADDRESS <u>Kensington, Md.</u>		M.D. <u>3924 Baltimore St.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-24-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockville Montg. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert R. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUNTED A. S.

MAY 27



MARYLAND

STATE DEPARTMENT OF HEALTH

4754

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>251 MANOR CIRCLE</u>		STREET ADDRESS (If rural, give location) <u>251 MANOR CIRCLE</u>	
3. NAME OF DECEASED (Type or Print) <u>BERTHA</u>	(First) <u>SHANKS</u>	(Middle) <u>CHANEY</u>	(Last)
4. DATE OF DEATH <u>MAY 21</u>	(Month)	(Day)	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 15, 1874</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CHATELAIN MINN.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES ALEXANDER SHANKS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>MRS JEANETTE WERMICH, 251 MANOR CIRCLE, TAKOMA PARK, MD.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)....

Myocardial Infarction

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)....

Atherosclerosis, Coronary & Generalized

(c)....

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 weeks

10 yrs.

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 27 April 1955, to 21 May, 1955, that I last saw the deceasedalive on 21 May, 1955, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE

L. B. Snow M.D.

Degree or title

Silver Spring, Md.

ADDRESS

DATE SIGNED

21 May 1955

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>MAY 24, 1955</u>	<u>Hillside Cemetery</u>	<u>Manassas, Va.</u>	<u>Mem.</u>
DATE REC'D BY LOCAL REG.	REGISTERED SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>MAY 21-1955</u>	<u>J. Arthur Walters</u>	<u>J. Arthur Walters</u>	<u>251 Carroll St. NE, Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 24 1965

BUREAU V. S.

48-1

CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Bethesda</u>		<u>42 days</u>		TOWN <u>Pittston</u>		<u>75 X-3</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>132 Elizabeth St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Edward J. Connors</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 27 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>September 8, 1875</u>	
9. AGE last birthday <u>79</u> yrs.		10. AGE last birthday <u>8</u> Months		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Manager (Retired)</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Bowling Alley</u>			
13. FATHER'S NAME: <u>Luke Connors</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Curley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Not available</u>			
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>160X Carcinoma of maxillary antrum with</u>							
ANTECEDENT CAUSE (B) <u>metastases to lung, liver, abdominal and thoracic lymph nodes</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Bronchopneumonia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from Apr. 15, 1955 to May 27, 1955, that I last saw the deceased alive on May 27, 1955, and that death occurred at 12:55 M. from the causes and on the date stated above.							
SIGNATURE <u>Harold Altman, M.D.</u>				DATE SIGNED <u>5/27/55</u>			
ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>				DATE THEREOF <u>5-30-55</u>			
NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>				LOCATION (City, town, or county) (State) <u>Pittston, Pa.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5/28/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Hampton</u>			
FUNERAL DIRECTOR <u>Robert G. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED V. S.

MAY 31 1961

RECEIVED

48-2

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>W. Virginia</u> COUNTY <u>Wyoming</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>115 days</u>		TOWN <u>Pineville</u> <u>85X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center National Institutes of Health</u>				STREET ADDRESS (If rural give location) -----			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>Booster</u>		<u>Charles</u> <u>Cook</u>		DATE OF DEATH: <u>May</u> <u>28</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	July 29, 1907	47 yrs.	Months 9	Days 31	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Miner		United Mine Workers		West Virginia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Cook</u>				<u>Joclie Workman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
no		not available		The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>576X</u>							
ANTECEDENT CAUSE (B) <u>Subdiaphragmatic abscess</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>May 16, 1955</u>		<u>Subdiaphragmatic abscess, intestinal obstruction</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 2, 1955, to May 28, 1955, that I last saw the deceased alive on May 28, 1955, and that death occurred at 5:50 AM, from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Fortner</u>		ADDRESS <u>The Clinical Center M. D. National Institutes of Health</u>		DATE SIGNED <u>5-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial-transit		5/28/55		Mullens		Mullens W. Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
5/28/55		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN A. S.

1955

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4803

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04778 Wc

Reg. Dist.

No. 216

1. PLACE OF DEATH:

COUNTY Montgomery MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) Kensington TOWN
LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS 4407 Clearbrook Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY MontgomeryCITY (If outside corporate limits write RURAL and give nearest town) Kensington TOWNSTREET ADDRESS (If rural, give location) 4407 Clearbrook Lane

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HarryArmandCox Sr.

4. DATE OF DEATH

(Month)

(Day)

(Year)

5919 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteMarriedOct. 13, 187678 yrs.8 Months 26 Days0 Hours 0 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Naval Architect ArchitectGovt.London EnglandUnited States

13. FATHER'S NAME:

Harry A. Cox

14. MOTHER'S MAIDEN NAME:

Emma Collins15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
Yes Spanish Amer.16. SOCIAL SECURITY No.: 577-38-5440-A17. INFORMANT & ADDRESS: Harry A. Cox Jr.
4906-Blackfoot Rd. College Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....
DUE TOCoronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b).....
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

Quadrant
death

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

M. D.

5-9-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

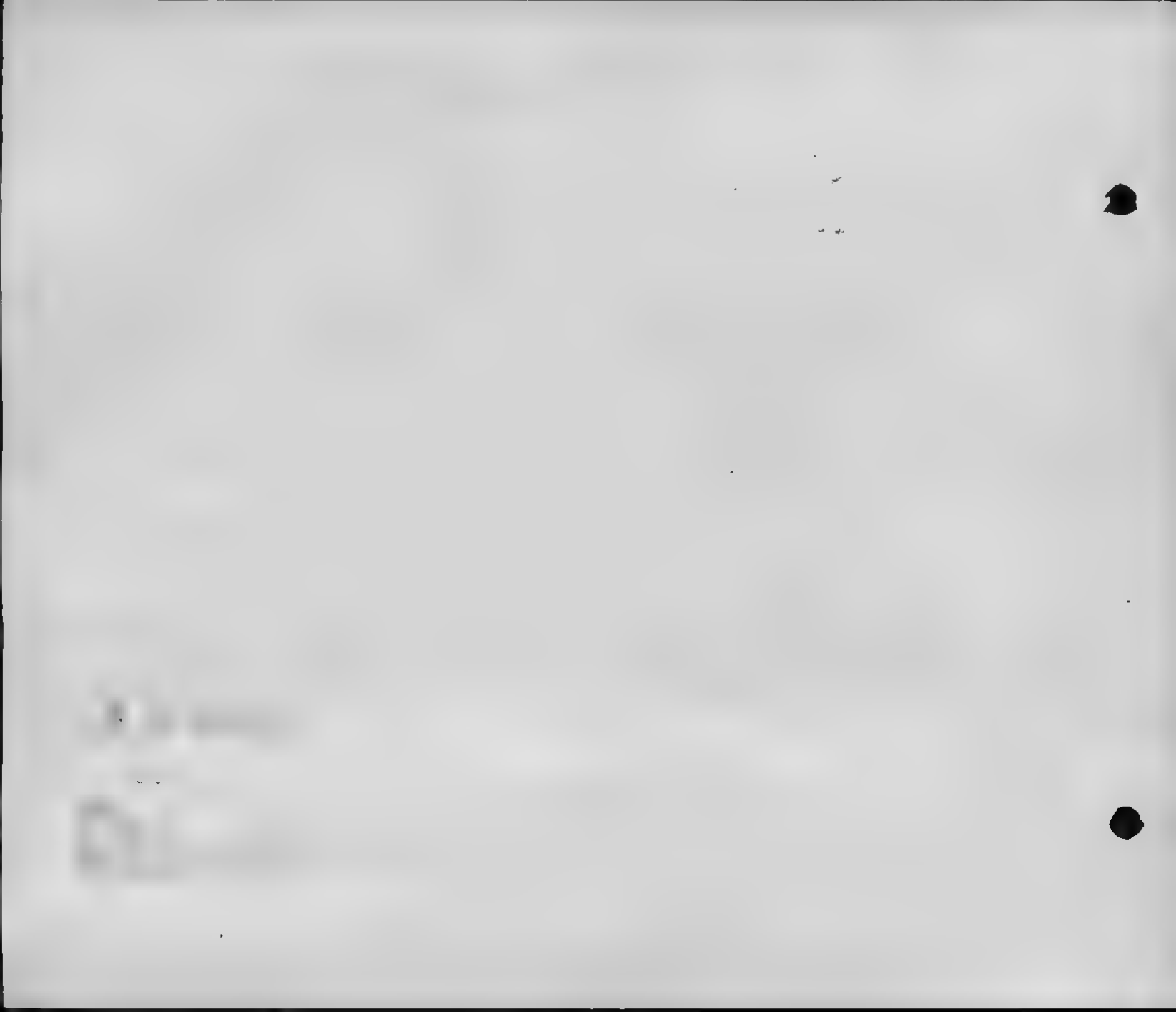
DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial5-12-55Arlington Nat'l Cem.Arlington, Arlington Va.Ar.5/10/55Bessie W. HunsickerRobert A. HumphreyChesapeake, Md.



4874

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Ohio</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>35 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>	STREET ADDRESS (If rural give location) <u>1673 Bunts Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Samuel Edward Crozier</u>		<u>May 16 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 16, 1895</u>
9. AGE last birthday <u>59 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stockman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Private industry</u>	
11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm. Crozier</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I & II</u>		16. SOCIAL SECURITY No. <u>297-30-7590</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>Infection</u>	
IMMEDIATE CAUSE (A) <u>Cellulitis, right leg with overulcerating</u>		<u>2-3 days</u>	
ANTECEDENT CAUSE (B) <u>Aplastic anemia with</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 11, 1955</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>3:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Franklin B. Elough</u>		ADDRESS <u>The Clinical Center</u>	
DATE SIGNED <u>5/19/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - Mount</u>		DATE THEREOF <u>5-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Pine Hill</u>		LOCATION (City, town, or county) (State) <u>Buffalo, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Benjamin Thompson</u>	
FUNERAL DIRECTOR <u>Robert D. Humphrey</u>		ADDRESS <u>Beth. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 23 1955

RECEIVED

4875

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Bethesda</u>		<u>35 days</u>		OR TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 The Clinical Center</u>				<u>Pooks Hill Apt. #303</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>William</u>		<u>Franklin</u>		<u>Cummins</u>			
4. DATE OF DEATH:		(Month)		(Day)		(Year)	
<u>May</u>		<u>3</u>		<u>1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>M</u>		<u>W</u>		<u>Married</u>		<u>December 20, 1907</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>47 yrs.</u>		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Engineer</u>		<u>Private industry</u>		<u>Mississippi</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME.			
<u>William Cummins</u>				<u>Janie Pickett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkn.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>W.W. #2</u>				<u>Not available</u>		<u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>Nov 15, 1954</u> <u>3</u>				<u>Ca of Stomach</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<u>None</u> <u>M.</u>							
22. I hereby certify that I attended the deceased from <u>Mar. 29, 1955</u> , to <u>May 3, 1955</u> , that I last saw the deceased alive on <u>May 3, 1955</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u>							
SIGNATURE <u>For J. S. Cholden</u>				DATE SIGNED <u>5-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>				<u>May 6, 1955</u>		<u>Mo</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>5/4/55</u>				<u>Bessie M. Thompson</u>		<u>Joseph Fowler's Sons, Wash., D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT V. S.

and

1911

4806

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY Montgomery		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (Rural)		LENGTH OF STAY (in this place) lmo 7 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 1003 Savannah Street, S.E.			
3. NAME OF DECEASED: (Type or Print)		(First) Dennis		(Middle) Charles		(Last) DEAN	
4. DATE OF DEATH:		(Month) May		(Day) 26		(Year) 19 55	
5. SEX Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 4-2-55	
9. AGE last birthday 1 yrs		IF UNDER 1 YEAR 1 Months		IF UNDER 24 HRS. 24 Days		Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Charles F. DEAN				14. MOTHER'S MAIDEN NAME: Mary C. GILROY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		(If Yes, give war or dates of service) - -		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Father Charles F. DEAN Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.							
IMMEDIATE CAUSE (A) Intestinal Obstruction, Duodenum						54 days	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Brain Damage						54 days	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 Apr , 19 55 , to 26 May , 19 55 , that I last saw the deceased alive on 26 May , 19 55 , and that death occurred at 10:05 PM from the causes and on the date stated above.							
SIGNATURE D. J. PASCOE				ADDRESS U. S. Naval Hospital, NMHC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 31 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 27 May 1955		REGISTRAR'S SIGNATURE Mary E. Barrell		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home		ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR HINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. 200000

1000

1000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4755

CERTIFICATE OF DEATH

Reg. Dist. No.

04782
223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park Md 17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 Lincoln Ave</u>		STREET ADDRESS (If rural give location) <u>109 Lincoln Ave</u>	
3. NAME OF DECEASED: (First) <u>Walter</u> (Middle) <u>Delaney</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 12 1955</u>	
5. SEX: <u>A</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>April 2, 1895</u>
9. AGE last birthday: <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Delaney</u>		14. MOTHER'S MAIDEN NAME: <u>Lucine King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>101-12-1000</u>	
17. INFORMANT & ADDRESS: <u>Waise Delaney, 109 Lincoln Ave</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>331X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cerebral Hemorrhage</u>			<u>36 hrs</u>
DUE TO			
(B) <u>Senile Arteriosclerosis, Generalized</u>			<u>10 yrs</u>
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>25 Apr., 1955</u> , to <u>12 May, 1955</u> , that I last saw the deceased alive on <u>12 May, 1955</u> , and that death occurred at <u>7:30 P M</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. E. Jarvis</u>		DATE SIGNED <u>12 May 1955</u>	
ADDRESS <u>Takoma Park</u>		M. D. <u>7112 Willow Ave</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-16-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington D.C.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>May 12 1955</u>		REGISTRAR'S SIGNATURE <u>John R. Dodd</u>	
24. FUNERAL DIRECTOR <u>W. E. Jarvis Co.</u>		ADDRESS <u>1422 14 St. N.W.</u>	

MURRAY A. S.

ALL TO

100-100000

4756

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		OR TOWN <i>17</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7600 Hammond Ave.</i>				STREET ADDRESS (If rural give location) <i>7600 Hammond Ave.</i>			
3. NAME OF DECEASED: (First) <i>Gertrude</i>		(Middle)		(Last) <i>Denniberg</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>May 24 1955</i>	
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>		8. DATE OF BIRTH: <i>April, 1880</i>	
9. AGE last birthday: <i>75</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Elliot Cohen</i>				14. MOTHER'S MAIDEN NAME: <i>Ukerson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>1</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <i>Mrs. Anne Louden - 7600 Hammond Ave. Takoma Park, Md.</i>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <i>Coronary Occlusion, Arteriosclerotic Heart Disease</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <i>Arteriosclerotic Heart Disease</i>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6-26</i> , 19 <i>55</i> , to <i>5-24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5-23</i> , 19 <i>55</i> , and that death occurred at <i>5:30</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>Isadore Hinkman</i>				ADDRESS <i>M.D. 915-19th St. N.W.</i>			
DATE SIGNED <i>May 25-1955</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 24, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Elisavetgrad Cemetery</i>		LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 25-1955</i>		REGISTRAR'S SIGNATURE <i>J. Nelson Dodd</i>		24. FUNERAL DIRECTOR <i>O. Vayansky & Son</i>		ADDRESS <i>Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.

MAY 28 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215.

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)X TOWN Bethesda, RuralLENGTH OF STAY
(in this place)
27 daysHOSPITAL OR
INSTITUTION ORSTREET ADDRESS U. S. Naval Hosrital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY MontgomeryCITY (If outside corporate limits, write RURAL and give nearest town)
ORTOWN Takoma ParkSTREET
ADDRESS

(If rural give location)

1100 Linden Ave., Apt 2013. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

EllsworthCalvinDE VAUGHN

4. DATE (Month)

(Day)

(Year)

OF
DEATH:May291955

5. SEX:

Male6. COLOR OR
RACE:White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Widowed

8. DATE OF BIRTH:

27 October 1893

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

61 yrs.

Months

Days

Hours

Mln.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Govt Employee10B. KIND OF BUSINESS
OR INDUSTRY:
U. S. Govt11. BIRTHPLACE (State or foreign country):
Washington, D.C.12. CITIZEN OF WHAT
COUNTRY?
U.S.

13. FATHER'S NAME:

Walter C. DE VAUGHN

14. MOTHER'S MAIDEN NAME:

Jane F. BERNISTON15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.)Yes(If Yes, give war or dates
of service) WWI WWII

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT & ADDRESS:

10608 Edgewood Ave.,
Walter C. DE VAUGHN Silver Spring, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY
LEADING TO DEATH

IMMEDIATE CAUSE

(A)

DUE TO

Myocardial infarctionINTERVAL BETWEEN
ONSET AND DEATH1 day

ANTECEDENT CAUSE (S)

(B)

DUE TO

Coronary occlusion, right coronary1 dayDISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

Generalized arteriosclerosis.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 May, 1955, to 29 May, 1955, that I last saw the deceased
alive on 29 May, 1955, and that death occurred at 6:15 AM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

F. H. CARY LT MC
BurialDATE THEREOF
1 June 1955NAME OF CEMETERY OR CREMATORY
USN U. S. Naval Hospital M. D. N. M. C. Bethesda, Maryland

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

30 May 1955Mary E. ParrellyHines Funeral Home
2901 14th Street, N.W., Washington, D.C.

MARGIN RESERVED FOR BINDING

BUREAU V. E.

JUN 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04785

Reg. Dist. No. 47

1. PLACE OF DEATH— COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>D. C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BOSWELL NURSING HOME 14511 COLESVILLE RD.</u>		STREET ADDRESS (If rural, give location) <u>3319 FESENDEEN ST. N.W.</u>	
3. NAME OF DECEASED (First) <u>NELLIE</u> (Middle) <u>VINCENT</u> (Last) <u>DISHMAN</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>29</u> (Year) <u>1955</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>27 FEB. 1871</u>
9. AGE last birthday <u>84</u> yrs. If under 1 year Months <u>2</u> Days <u>27</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>	
11. BIRTHPLACE (State or foreign country) <u>ALEXANDRIA VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM VINCENT</u>		14. MOTHER'S MAIDEN NAME <u>SINA SIMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>EUSTACE M. PEIX-OTTO 3319 FESENDEEN ST. N.W. WASHINGTON, D.C.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>BRONCHOPNEUMONIA</u>		<u>2 1/2 mos.</u>	
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>SENILITY</u>			
(c) <u>ARTIOSCLEROSIS</u>			
(d) <u>PARKINSONISM</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>N.A.</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>N.A.</u> (CITY OR TOWN) (COUNTY) (STATE)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>N.A.</u> m. INJURY OCCURRED White at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>OCT. 25, 1952</u> to <u>MAY 29, 1955</u> , that I last saw the deceased alive on <u>MAY 29, 1955</u> , and that death occurred at <u>6:40 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>David C. White</u> (Degree or title) <u>Maj. MC.</u>		ADDRESS <u>Walter Reed Army Hosp.</u> DATE SIGNED <u>29 May 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u> DATE THEREOF <u>5/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Alexandria, Va.</u> (State)	
DATE REC'D BY LOCAL REG. <u>1-30</u> REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Josiah S. Evelyn</u> ADDRESS <u>md. No. 827</u>	

U. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 217

04786

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Olney</u> TOWN <u>Brookeville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Brookeville</u> TOWN <u>Brookeville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc</u>				STREET ADDRESS (If rural give location) <u>Brookeville</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Henry Dowling</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 25 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3/16/1892</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George E. Dowling</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Efford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>✓</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Massive Pulmonary Edema</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Congestive Heart Failure</u>						<u>6 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Heart Disease</u>						<u>5-6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24, 1955</u> , to <u>May 25, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard A. Yates</u>		M.D. <u>Olney, Md.</u>		DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>May 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkland</u>		LOCATION (City, town, or county) (State) <u>Water 4 721</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-28-55</u>		REGISTRAR'S SIGNATURE <u>Bertine B Lawler</u>		34. FUNERAL DIRECTOR <u>Wm. W. Barkus</u>		ADDRESS <u>Wilmington</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sakoma Park</u> LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyattsville, Md.</u> 16-1-12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>708 Philadelphia Ave.</u>		STREET ADDRESS (If rural, give location) <u>6103 Eastern Ave. Apt 102</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JESSIE</u>	(Middle) <u>A.</u>	(Last) <u>EARMAN</u>
4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	7. DATE OF BIRTH <u>Aug. 25, 1872</u>
8. DATE OF DEATH <u>MAY 19 1955</u>	9. AGE last birthday <u>82 yrs.</u>	10. If under 1 year Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) <u>PRINCE EDWARD ISLAND, CANADA</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	13. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	15. MOTHER'S MAIDEN NAME <u>MARGARET PERCIVALE</u>
16. FATHER'S NAME <u>JOHN MAC DONALD</u>	17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	18. (If year, give war or dates of service)	19. SOCIAL SECURITY NO.
20. INFORMANT <u>Mrs. Louise Coffman, 6103 Eastern Ave. Hyatts. Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause <u>(1) Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
Antecedent cause(s) <u>(2) Generalized Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(3) Cerebro-sclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from May 17, 1955 to May 19, 1955, that I last saw the deceased alive on May 17, 1955, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 22, 1955</u>	<u>Woodlawn Cemetery</u>	<u>Hagerstown, Md.</u>	<u>Va.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 20, 1955</u>	<u>J. M. M. Dodd</u>	<u>Stallings</u>	<u>254 Carroll St. N.W.</u>	

BUREAU V. S.

MAY 28 1955

VED

4811

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Chevy Chase</u>		LENGTH OF STAY (in this place) <u>One year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4757 Chevy Chase Drive</u>				STREET ADDRESS (If rural give location) <u>4757 Chevy Chase Drive</u>			
3. NAME OF DECEASED: (First) <u>Martha</u>		(Middle) <u>K.</u>		(Last) <u>EIKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>1</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 8, 1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Oscar King</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Chandler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Karl V. Eiker-Same Item #2</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
467-1 IMMEDIATE CAUSE (A) <u>cerebral vascular accident</u>						10 wks.	
ANTECEDENT CAUSE (B) <u>familial telangiectasia</u>						<u>congenital</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>coronary artery disease</u>						5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1955</u> , to <u>May 1, 1955</u> ; that I last saw the deceased alive on <u>May 1, 1955</u> and that death occurred at <u>12:47 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. 7852 16 1/2 W. Walden</u>		DATE SIGNED <u>5/1/55</u>			
23. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		DATE THEREOF <u>5/3/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/2/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 3

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4810 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04788

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: <i>Montgomery</i>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL or give nearest town)			
X TOWN <i>Rockville</i>		<i>35 years</i>		TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7 Locks Road</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <i>Emily Bland Edgine</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>5/30 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>September 17/1911</i>	
9. AGE last birthday: <i>43</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Montgomery</i>	
13. FATHER'S NAME: <i>Walter M. Bland</i>				14. MOTHER'S MAIDEN NAME: <i>Emily Zeller</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT'S ADDRESS: <i>John E. Edgine - Box 483 - Rockville</i>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Carcinoma of right breast,</i>						<i>4 1/2 years</i>	
ANTECEDENT CAUSE (B) <i>with metastasis to lungs.</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19A. DATE OF OPERATION: <i>October 1950</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of right breast</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, or injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950</i> , to <i>May 30, 1955</i> , that I last saw the deceased alive on <i>May 30, 1955</i> , and that death occurred at <i>1 P. M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm. H. Kuthman</i>				ADDRESS <i>Rockville, Md.</i>		DATE SIGNED <i>May 30/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 2/55</i>		NAME OF CEMETERY OR CREMATORY <i>Monacacy</i>		LOCATION (City, town, or county) (State) <i>Beallsville - Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/31/55</i>		REGISTRAR'S SIGNATURE <i>Lamell H. Kugler</i>		24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Rockville, Md.</i>	

1. A. C. C. C.

1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4812 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 047311

CERTIFICATE OF DEATH

Reg. Dist. No. 216

item 7, Film G182 6-7-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>5/19/55 - 5/21/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	OR TOWN <u>Boyd's</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>	STREET ADDRESS (If rural give location) <u>Route #1</u>		
3. NAME OF DECEASED: (Type or Print) <u>Harriet Evans</u>		4. DATE OF DEATH: <u>May 21, 1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>5/4/76</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Witchman, Clarence</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Wales</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME <u>David Evans</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 57-1199</u>	
17. INFORMANT & ADDRESS: <u>Alvin L. Evans</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>		<u>24 hours</u>	
ANTECEDENT CAUSE (B) <u>Coronary Thrombosis</u>		<u>6 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u>		(C) <u>Arteriosclerotic-Cardiovascular Disease</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>		<u>12 years</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11 May, 1955</u> , to <u>21 May, 1955</u> that I last saw the deceased alive on <u>21 May, 1955</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John W. Smith</u>		DATE SIGNED <u>21 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 24-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/29/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>William B. Hilton</u>		ADDRESS <u>Barnesville</u>	

WILFRED V. S.

MAY 21 1964

RECEIVED
MAY 21 1964

4813

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Virginia</u> COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Bethesda Rural</u>	LENGTH OF STAY (in this place) <u>10hrs 25 min</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>2801 North Somerset Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Clifton Joseph FALCON</u>		OF DEATH: <u>4</u> <u>May</u> <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-4-01</u>
		9. AGE last birthday <u>53</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mariner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Mariner Retired</u>	11. BIRTHPLACE (State or foreign country): <u>Louisiana</u>
13. FATHER'S NAME: <u>Simon FALCON</u>		14. MOTHER'S MAIDEN NAME: <u>DRALIN ALLMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WW II Korea</u>		16. SOCIAL SECURITY No. <u>579 44 7039</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Mary E. FALCON (WIFE)</u>		<u>Same as above</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>coronary artery</u>			<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>sclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3 May</u> .., 1955, to <u>4 May</u> .., 1955, that I last saw the deceased alive on <u>4 May</u> 19 <u>55</u> and that death occurred at <u>5:25A</u> , from the causes and on the date stated above.			
SIGNATURE <u>M. E. Flipse</u>		ADDRESS DATE SIGNED	
M. E. FLIPSE LCDR, MC, USN		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6 May 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4 May 1955</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	
FUNERAL DIRECTOR <u>R. A. Humphrey Funeral Home</u>		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6. 27. 43

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1. 1. 1944

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4814

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04792

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>10 mo 25 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>		<u>41</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>3120 38th Street, N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Walton Canby FERRIS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 9 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-2-00</u>	9. AGE last birthday <u>54 yrs.</u>	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>U.S. Govt</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>State Department</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Walter FERRIS</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah PRICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Mrs. Sarah FERRIS</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Asphyxia, Brain</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>12/3/1954</u>		19B. MAJOR FINDINGS OF OPERATION <u>Brain tumor</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 June, 19 54</u> to <u>9 May</u> , 19 <u>55</u> , that I last saw the deceased <u>alive on 9 May</u> , 19 <u>55</u> , and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above. SIGNATURE <u>W. Mackie</u> ADDRESS <u>MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>11 May 55</u>		NAME OF CEMETERY OR CREMATORY <u>Prince George County Crematory</u>		LOCATION (City, town, or county) (State) <u>Maryland and Interment Rock Creek Park Cemetery Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9 May 1955</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelley</u>		24. FUNERAL DIRECTOR <u>Gavlers Funeral Home</u>		ADDRESS <u>1756 Penn Avenue, Washington, D.C.</u>	

U. S. A. 1910



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4815 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01793

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>BETHESDA</u>		<u>2 days</u>		TOWN <u>SILVER SPRING, MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>24</u> <u>SUBURBAN HOSPITAL</u>				<u>213 CRESTMOOR CIRCLE</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(Type or Print) <u>ROBERT ALLEN FOSTER</u>				<u>MAY 20 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>4/27/09</u>	
				9. AGE last birthday: <u>66</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Felix A. Foster</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Phifer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Neely Foster</u> <u>213 Crestmoor Circle, Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X		(A)		<u>Cerebral Thrombosis</u>			
IMMEDIATE CAUSE		DUE TO					
ANTECEDENT CAUSE (S)		(B)		<u>Cerebral Arteriosclerosis</u>		<u>1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO					
(260X)		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Diabetes Mellitus</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>May, 23</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James A. Roberts</u>		ADDRESS <u>M.D. 8907 Geo. Ave. Silver Spring, Md.</u>		DATE SIGNED <u>May 25, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-28-55</u>		<u>H. Lincoln</u>		<u>Pr. Geo. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/28/55</u>		<u>Bessie M. Thompson</u>		<u>Deaf Funeral Home</u>		<u>4812 Barclay St. Wash. D.C.</u>	

BUREAU V. S.

MAY 21 1915

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Monte</u>		MARYLAND		STATE <u>Calif</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gabriel Park</u>		LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Claremont</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanatorium</u>				STREET ADDRESS (If rural give location) <u>760 West 9th St.</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>A.</u> (Last) <u>Fritz</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 7 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>SEPT. 11, 1903.</u>	9. AGE last birthday: <u>51</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>SALES MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>SOUND-STATE DIST. INC</u>		11. BIRTHPLACE (State or foreign country): <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HENRY FRITZ</u>				14. MOTHER'S MAIDEN NAME: <u>LOUISE BARTO</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown. If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT'S ADDRESS: <u>MRS. JOHN FRITZ 760 W. 9th St. CLAREMONT, CALIF.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>						<u>24 days</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Terminal uremia</u>							
19A. DATE OF OPERATION: <u>1 May 55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>No cause for intestinal obstruction found</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 13, 1955</u> to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>May 7, 1955</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>M.D. 2902 Porter St. N.W. Wash. D.C.</u> DATE SIGNED <u>May 7, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial - Transferred</u>		<u>May 12, 1955</u>		<u>Pomona Cemetery</u>		<u>Pomona Calif.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 7 1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>		24. FUNERAL DIRECTOR <u>251 Canal St. N.W. Atlanta Ga 12, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[illegible]

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4759 CERTIFICATE OF DEATH

Reg. Dist. No. 223

04795

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Pr. Geo.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 TOWN Takoma Park</u>	LENGTH OF STAY (in this place) <u>3 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Hyattsville</u>	<u>16-1</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Washington Sanitarium & Hosp.</u>		STREET ADDRESS (If rural give location) <u>3040 Powder Mill Road</u>	
3. NAME OF DECEASED: (First) <u>Ida</u> (Middle) <u>Louise</u> (Last) <u>Fuller</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>5-24-1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-4-1885</u>
9. AGE last birthday: <u>69</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-9</u>	
13. FATHER'S NAME: <u>Clarence Bond</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth L. Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>no</u>		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>Washington Sanitarium & Hospital Records</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
201X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO <u>Malignant lymphoma, probable Hodgkin type</u>		3 yrs.	
(B) DUE TO <u>401</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Sept 1954</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Gleulectomy</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY OCCURRED	
21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 3 1952</u> to <u>5-24 1955</u> , and that death occurred at <u>10:35</u> AM, from the causes and on the date stated above.			
alive on <u>5-24</u> , 1955, and that death occurred at <u>10:35</u> AM, from the causes and on the date stated above.		DATE SIGNED <u>5-24-55</u>	
SIGNATURE <u>J. Arthur Halber</u>		ADDRESS <u>M. D. Takoma Park - Takoma Park</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 24-1955</u>		REGISTRAR'S SIGNATURE <u>J. Arthur Halber</u>	
24. FUNERAL DIRECTOR <u>254 Central St. N.W.</u>		ADDRESS <u>Washington D.C.</u>	

RECEIVED

MAY 23 1955

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md 04796
4816
CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 56 <u>Silver Spring</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 56 <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1014 Merrimac Drive</u>				STREET ADDRESS (If rural give location) <u>1014 Merrimac Drive</u>			
3. NAME OF DECEASED: (First, Middle, Last) <u>Corinne Newman Gaskins</u>				4. DATE OF DEATH: (Month, Day, Year) <u>May 25 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>3-29-1861</u>	9. AGE last birthday: <u>94</u> yrs.	10. UNDER 1 YEAR: <u>1</u> Months	11. UNDER 24 HRS: <u>26</u> Days	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Orange, Virginia</u>	
13. FATHER'S NAME: <u>James Newman</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Laughter-Mrs. Dorothy P. Trayfors</u> <u>1014 Merrimac Dr. SS Md</u>			
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>4 1/2</u> Immediate cause (a) <u>Myocardial Infarction</u> Antecedent causes (s) (b) <u>Coronary Artery Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Since 3 1/2 yrs</u> <u>Cholesterol</u>				<u>26 yrs</u> <u>6 1/2 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>May 25 1955</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 25</u> , 19 <u>55</u> , to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>1014 Merrimac Dr. Silver Spring, Md</u> from the causes and on the date stated above. SIGNATURE <u>Frances Toller</u> ADDRESS <u>1014 Merrimac Dr. Silver Spring, Md</u> DATE SIGNED <u>5/25/55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATOR		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-27-55</u>		<u>Catlett Cemetery</u>		<u>Fauquier Co. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>May 27 1955</u>		<u>Frances Toller</u>		<u>Robert A. Campbell</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

10/1/54

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04797

4817

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Montgomery</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>1 week</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	OR TOWN <u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>	STREET ADDRESS (If rural give location) <u>2010 Janier Drive</u>		
3. NAME OF DECEASED: (Type or Print) <u>Opilup H. George</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 17 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 28, 1878</u>
10A. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <u>Supt. Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gov. Print. Off.</u>	9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. <u>77</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Henry George</u>		14. MOTHER'S MAIDEN NAME: <u>Pauline Page</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>78-30-350</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Hazel Hozell</u>		1904 <u>7th St. Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>			<u>10 days</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19A. DATE OF OPERATION <u>None</u>		19B. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1950</u> to <u>May 17 1955</u> that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>6 13 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Marion Bausch</u>		DATE SIGNED <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (C.O., town, or county) (State) <u>Silver Spring, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		8434 Ga. Ave. <u>Silver Spring, Md.</u>	

BUREAU V. E.

MAY 20 1

RECEIVED

BUREAU V. S.

MAY 23 1911

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4819
CERTIFICATE OF DEATH

04799

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montg.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Damascus		RURAL LENGTH OF STAY (in this place) 9 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Damascus		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. # 3 Mt. Airy				STREET ADDRESS (If rural give location) R.F.D. #3 Mt. Airy			
3. NAME OF DECEASED: (First) Mary		(Middle) Catherine		(Last) Gobble		4. DATE OF DEATH: (Month) May (Day) 23 (Year) 19 55	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed		8. DATE OF BIRTH: June 16, 1882	
				9. AGE last birthday: 72 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Sneedville, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andrew J. Orick				14. MOTHER'S MAIDEN NAME: Martha Buckles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: --		17. INFORMANT & ADDRESS: James E. Gobble, Mt. Airy, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
502.0 Immediate cause (a) Arteriosclerotic cardiovascular disease						2 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chronic bronchitis & emphysema						7 years	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: May 23, 1955				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 2, 1951 , to May 23, 1955 , that I last saw the deceased alive on May 13, 1955 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
SIGNATURE James E. Gobble (Degree or title)				ADDRESS Damascus, Md. DATE SIGNED 5/25/55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 26, 1955		Pleasant Hill		Monrovia, Fred. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 25, 1955		Della M. Burdette		Cliff L. McIsaith		Damascus, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BOHANNON V. S.

MAY 1964

1964

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04800

4760 CERTIFICATE OF DEATH

Reg. Dist. No. 222

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District</u> COUNTY of <u>Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Takoma Park</u>		<u>9 days</u>		TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & Hosp.</u>				STREET ADDRESS (If rural give location) <u>5014 42nd St NW</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Rupert Grantham</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 3 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 16, 1899</u>	9. AGE last birthday: <u>55</u> yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charlie R. Grantham</u>				14. MOTHER'S MAIDEN NAME: <u>Mona Shaw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>21-411</u>		17. INFORMANT & ADDRESS: <u>Wash. San. & Hosp. Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						terminal	
465X IMMEDIATE CAUSE (A)		<u>Massive embolism, pulmonary arteries</u>					
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						few days	
19A. DATE OF OPERATION: <u>26 April '55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Vein stripping for varicosities, left lower extremity</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-25-55</u> to <u>5-3-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-3-55</u> , 19 <u>55</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur E. Coyle MD</u>				ADDRESS <u>M. D. Takoma Park Md 5-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem</u>		LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4 1955</u>		REGISTRAR'S SIGNATURE <u>William D. Dold</u>		24. FUNERAL DIRECTOR <u>Chapman Funeral Home</u>		ADDRESS <u>Wash. DC</u>	

BUREAU V. S.

MAY 6 1



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04801

4820

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Kensington Md.</u> OR TOWN <u>Kensington Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kensington Gardens Kensington Md.</u>		STATE <u>MARYLAND</u> COUNTY <u>MONT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> OR TOWN <u>Chevy Chase</u> STREET ADDRESS (If rural give location) <u>4572 Stanford St</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>MARY</u> (Middle) <u>B</u> (Last) <u>GREENWAY</u> (Type or Print)		(Month) <u>5</u> (Day) <u>9</u> (Year) <u>1955</u> DEATH:	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 17 1865</u>
9. AGE: <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>9</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Madison, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas J. Turpin</u>		14. MOTHER'S MAIDEN NAME: <u>Ann M. C. Dwyer</u>	
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>Mr. Geo. E. Greenway, 4412 Stanford St. Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE: <u>443X</u> ANTECEDENT CAUSE (B): <u>Hypertensive heart disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST: <u>Hepatitis</u>		<u>5 years</u> <u>1 mth</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>May 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 8</u> , 19 <u>55</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE: <u>Dr. Joseph H. Smith</u>		ADDRESS: <u>6450 Wisconsin Ave, P. 24, Md.</u>	
DATE SIGNED: <u>5-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Trans. & Burial</u>		DATE THEREOF: <u>5/9/55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Lakewood Cemetery</u>		LOCATION (City, town, or county) (State): <u>Jackson, Mississippi</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>5-10-55</u>		REGISTRAR'S SIGNATURE: <u>Francis E. Warner</u>	
24. FUNERAL DIRECTOR: <u>Warner & Humphrey</u>		ADDRESS: <u>8434 Ga. Ave. Silver Spring, Md.</u>	

3 A 1000

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

04802

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herbert</u>	(Middle) <u>Lee</u>	(Last) <u>Harding</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>16</u>	(Year) <u>1955</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>9/28/1889</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Granville Harding</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-05-8588</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Herbert Harding, Sandy Spring Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>15 min.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>			<u>4 years.</u>
(c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 22</u> , 19 <u>55</u> , to <u>5/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/14</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Sandy Spring, Maryland</u> DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 15/55</u>	NAME OF CEMETERY OR CREMATORY <u>Union Burial & Crematory Co</u>	LOCATION (City, town, or county) (State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>5-19-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Signature]</u>

BUREAU V. S.

MAY 23 1955

RECEIVED

4822

04803

CERTIFICATE OF DEATH

Reg. Dist. No.

276

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pethesda</u>		<u>60 days</u>		OR TOWN <u>Wheaton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Clinical Center</u>				<u>11701 Grandview Avenue</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Rosanna</u>		(Middle) <u>---</u>		(Last) <u>Harns</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>October 8, 1920</u>		9. AGE last birthday: <u>34</u> yrs. <u>1</u> Months <u>1</u> Days <u>19</u> Hours <u>55</u> Min.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>Joseph Musgrove</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME: <u>Hazel Ammon</u>				17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None Not Available</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Acute lymphocytic leukemia</u>				<u>3 mos</u>			
ANTECEDENT CAUSE (B) <u>Staphylococcus aureus septikemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>---</u>		19B. MAJOR FINDINGS OF OPERATION: <u>---</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 2, 1955, to May 1, 1955, that I last saw the deceased alive on May 1, 1955, and that death occurred at 6 A M, from the causes and on the date stated above.							
SIGNATURE <u>Herold W. Burton</u>		M.D. <u>The Clinical Center</u>		ADDRESS <u>National Institutes of Health</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockville Pike, Montg. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Horn</u>		24. FUNERAL DIRECTOR <u>Maxner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—~~REGISTRATION~~ 18

4823

CERTIFICATE OF DEATH

Reg. Dist. No.

04804

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montg.</u>			
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town)				CITY (If outside corporate limits, write RURAL, and give nearest town)			
X TOWN <u>Cabin John</u>				TOWN <u>Cabin John</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6424-79th St.</u>				STREET ADDRESS (If rural give location) <u>6424-79th St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		<u>MYRTLE A HILL</u>		<u>MAY 19 1955</u>		<u>19</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>June 30, 1888</u>	<u>66</u> yrs.	<u>10</u> Months	<u>19</u> Days	<u>19</u> Hours
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country).		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Cropley Maryland</u>		<u>US</u>	
13. FATHER'S NAME: <u>William T. Redden</u>				14. MOTHER'S MAIDEN NAME: <u>Isabelle Pennfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS.			
<u>No</u>		<u>None</u>		<u>Husband - 6424-79th St. Cabin John, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
191X Immediate cause <u>Melanotic adenocarcinoma of cerebrum</u> DUE TO							
Antecedent cause(s) <u>Adenocarcinoma of sebaceous gland of left cheek with multiple subcutaneous metastasis and to lung right</u> DUE TO							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Interval Between Onset And Death	
<u>1-6-12-53</u>		<u>Adenocarcinoma of sebaceous gland left cheek</u>		<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>		<u>2 years.</u>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)			
(Specify)		INJURY		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED					
OF INJURY		While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>6:30</u> , 19 <u>54</u> , to <u>MAY 18 1955</u> , that I last saw the deceased alive on <u>MAY 18, 1955</u> , and that death occurred on <u>4:10 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		C. P. RYLAND		ADDRESS		DATE SIGNED	
<u>C. P. Ryland</u>		<u>4100 49th St., N. W.</u>		<u>Washington 16, D. C.</u>		<u>MAY 19 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/23/55</u>		<u>Parklawn</u>		<u>Montg. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/21/55</u>		<u>Bessie M. Thompson</u>		<u>Robert C. Thompson</u>		<u>Bethesda, Md.</u>	

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4824
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01805
 Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Germanstown</u>		<u>10 yrs</u>		TOWN <u>Germanstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 2</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. # 2</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William</u>				<u>Hoes</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>cal</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Sept 13, 1913</u>	
9. AGE last birthday: <u>41</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Ernest Hoes</u>				14. MOTHER'S MAIDEN NAME: <u>Delia Corn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>World War II</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Woodrow Hoes, Germanstown, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>Coronary occlusion</u>							
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-5-55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		LOCATION (City, town, or county) (State) <u>Brownstown, Md</u>	
DATE REC'D BY LOCAL REG. <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Kraybill</u>		24. FUNERAL DIRECTOR <u>Robert L. Snodden</u>		ADDRESS <u>Pockville, Md</u>	

S. A. 100

4825

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		13 days		OR TOWN <u>Alexandria</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Clinical Center</u>				<u>915 N. Alfred Street</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Lydia Belle Holmes</u>				OF DEATH: <u>May 1 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>January 12, 1931</u>	<u>24</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):			
<u>Housewife</u>				<u>North Carolina</u>			
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>John Evans</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>Not Available</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>The medical record, The Clinical Center</u>				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Congenital heart disease</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>Hydropericardium</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Congestion of the lungs and liver</u>			
				DUE TO <u>Partially healed closure of patent interatrial septal defect</u>			
				(C) <u>Partially healed surgical incision of thorax</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Fibrous adhesions about the Fallopian tubes and scattered over the small intestines</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>4-21-55</u>		<u>Interatrial septal defect</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 18 1955</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>May 1, 1955</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Andrew G. Monow</u>		<u>The Clinical Center</u>		<u>5/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/6/55</u>		<u>Arlington Natl</u>		<u>Arlington, Va</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/2/55</u>		<u>Bessie M. Thompson</u>		<u>L.A. Lewis</u>		<u>800 Wolfe St. Alex. Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1

1907
MAY 5 1907
1907

CERTIFICATE OF DEATH

Reg. Dist. No. 215

4826

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>2 hrs 33 min</u>		<u>Alexandria</u> <u>83X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>811 North Overlook Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Douglas (n) HOUSER</u>				<u>May 30 1955</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-30-55</u>			<u>2</u>	<u>33</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>None</u>			<u>None</u>		<u>Bethesda, Maryland</u>		<u>US</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME.			
<u>William D. HOUSER</u>				<u>Betty L. Worrall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service):			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
<u>No</u>			<u>None</u>		<u>Father CDR William D. HOUSER</u> <u>Same as above</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>Prematurity</u>							<u>2hr 33 min.</u>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>30 May, 1955</u> , to <u>30 May, 1955</u> , that I last saw the deceased alive on <u>30 May, 1955</u> , and that death occurred at <u>5:15AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. S. Allen</u>				ADDRESS		DATE SIGNED	
23. M. S. ALLEN, M.D., U.S. Naval Hospital, Bethesda, Maryland							
REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR			
<u>Burial</u>				<u>Cunningham Funeral Home</u>			
<u>8 June 1955</u>				<u>Arlington National Cemetery Arlington, Virginia</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2 June 1955</u>		<u>Mary E. Sweeney</u>		<u>Alexandria, Virginia</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED V. S.

NOV 3 1955

11

4827

CERTIFICATE OF DEATH

Reg. Dist. No.

04808
276

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>W. Virginia</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>ethesda</u>	<u>23</u> days	TOWN <u>Belle, West Virginia</u>	<u>P. X</u>
HOSPITAL OR INSTITUTE OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>The Clinical Center</u>		<u>1831 West Dupont</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Dana M. Huddleston</u>		<u>May 10 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>F</u>	<u>W</u>	<u>Single</u>	<u>6 Dec/ 1891</u>
9. AGE last birthday: <u>63</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Huddleston</u>		14. MOTHER'S MAIDEN NAME: <u>Georgia Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service) <u>Yes V W.W. I</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>160X</u>			
IMMEDIATE CAUSE		(A) <u>Massive pulmonary embolus</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Epidermoid carcinoma of right maxillary</u>	
		DUE TO <u>sinus with extension through to cranial cavity</u>	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>24 May 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Epidermoid carcinoma of right maxillary sinus.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>None</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 18, 1955</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>3:35 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James A. Pittman</u>		DATE SIGNED <u>May 10, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL - 5-10-55</u>		<u>MONTGOMERY MEM. PARK</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>A. H. Hines Co., Washington 9, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD A. S.

RECEIVED

4828

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4612 Montgomery Ave.</u>		STREET ADDRESS (If rural give location) <u>4612 Montgomery Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNIE</u> <u>HUDGINS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 18,</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 3, 1857</u>
9. AGE last birthday <u>97</u> yrs		10. IF UNDER 1 YEAR: <u>8</u> Months <u>10</u> Days	11. IF UNDER 24 HRS. <u>10</u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Andrew Cottee</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Ida C. Poole- Item# 2</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROTIC CARDIO</u>		<u>YEARS</u>	
ANTECEDENT CAUSE (B) <u>VASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Hemorrhagic Cystitis</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953 to May 18, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>De Witt E. DeLawter</u>		DATE SIGNED <u>5/18/55</u>	
ADDRESS <u>8025 Aberdeen Rd Bethesda Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNDAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4829

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04810

CERTIFICATE OF DEATH

Reg. Dist. No. 215

Item 5, Film 181 5-18-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda Rural</u>		<u>2 Mos. 14 da.</u>		Washington <u>47x</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>Westchester Apts</u> ✓			
3. NAME OF DECEASED: (First) <u>William</u>		(Middle) <u>Lambert</u>		(Last) <u>Huggins Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 7 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Cauc</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>17 Jun 1902</u>	
9. AGE last birthday: <u>52</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Public Relations Railroad</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Kansas</u>	
13. FATHER'S NAME: <u>William L. HUGGINS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
14. MOTHER'S MAIDEN NAME: <u>Emma SPOHR</u>				17. INFORMANT & ADDRESS: <u>Son: William L. HUGGINS 504 W Garden Rd. Oreland, Penna.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes 2/42 - 9/45</u>				16. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				237X			
IMMEDIATE CAUSE (A) <u>Brain tumor, left cerebrum</u>				7 months			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>28 Dec 1954</u>		19B. MAJOR FINDINGS OF OPERATION: <u>No evidence of tumor</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Feb</u> , 1955, to <u>7 May</u> , 1955, that I last saw the deceased alive on <u>7 May</u> , 1955, and that death occurred at <u>6:25 M</u> , from the causes and on the date stated above.							
E. P. THELEN, LCDR MC USN U.S. Naval Hospital M.D. NMMC, Bethesda, Maryland				DATE SIGNED <u>7 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-10-55</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7 May 1955</u>		<u>Mary E. Parrelly</u>		<u>Chambers Funeral Home</u>		<u>3072 M St. N.W. Washington, D.C.</u>	

RODRIGUEZ A. S.

4830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Loudoun</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		<u>8 Days</u>		OR TOWN <u>Round Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>- -</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Arthur (n) INGERSOLL</u>				<u>May 21 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Caucasian</u>	<u>Widowed</u>	<u>4-24-67</u>	<u>88 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired</u>				<u>School Teacher</u>		<u>Massachusetts</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Ingersoll</u>				<u>Mehitable Waterhouse</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Son Stuart H INGERSOLL</u> <u>Same as above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>491X</u>							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, organism unknown</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 May, 1955</u> , to <u>21 May, 1955</u> , that I last saw the deceased alive on <u>21 May</u> , 1955, and that death occurred at <u>10:25 am</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>G. BAMBERG LT MC USN</u>		<u>Pg. Bowling</u>		<u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>24 May 1955</u>		<u>Cedar Hill Crematory Prince George Co, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>23 May 1955</u>		<u>Mary C. Sarselly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Ave. Bethesda, Maryland</u>	

BUREAU V. S.

MAY 22 1971

100-100000-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4831

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804812

CERTIFICATE OF DEATH

Reg. Dist. No. 213

item 7, Film G182 6-7-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Barnestown</u>		LENGTH OF STAY (in this place) <u>18 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barnestown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gaithersburg, R.T.D. #3</u>				STREET ADDRESS (If rural give location) <u>Gaithersburg, R.T.D. #3</u>			
3. NAME OF DECEASED: (First) <u>HARRY</u> (Middle) (Last) <u>JOPPY</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 30, 1893</u>	
9. AGE last birthday: <u>62</u> yrs.		10. MONTHS: <u>13</u>		11. DAYS: <u>5</u>		12. HOURS: <u>1</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Joppy</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Joppy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4</u>		16. SOCIAL SECURITY No.: <u>NO</u>		17. INFORMANT & ADDRESS: <u>William Joppy, Rockville, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Cerebral thrombosis</u>							
Antecedent causes (s) (b) <u>Atherosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>obesity</u>							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 May, 1955</u> , to <u>31 May 1955</u> , that I last saw the deceased alive on <u>31 May, 1955</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John S. Lawrence, M.D.</u>				ADDRESS <u>Rockville, Md.</u>			
23. DATE REC'D BY LOCAL REGISTRAR <u>6/2/55</u>		REISTRAR'S SIGNATURE <u>Laurel H. Hagloep</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		LOCATION (City, town, or county) <u>Rockville, Md.</u>		(State) <u>Md.</u>	

1000000 V. 2

JUN 8 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4761

CERTIFICATE OF DEATH

Reg. Dist. No. 0481223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>17 TOWN - Lapoma Park</u>	LENGTH OF STAY (in this place) <u>29 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lapoma Park</u>	<u>17</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7215 4th Avenue</u>		STREET ADDRESS (If rural give location) <u>7305 Holly Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>PERRY LESLIE KEEFER</u>		<u>May 4 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>November 16, 1880</u>
9. AGE last birthday: <u>74</u> yrs.		10. MONTHS: <u>4</u>	11. DAYS: <u>19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Attorney</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. GOVT. SERVICE</u>	11. BIRTHPLACE (State or foreign country): <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Eugene F. Keefe</u>	
14. MOTHER'S MAIDEN NAME: <u>Nester Anne</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Bessie M. Keefe, 7305 Holly Ave. T.O. Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Myocardial Failure</u>			<u>15 min.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 1955, to <u>April</u> , 1955, that I last saw the deceased alive on <u>April 7, 1955</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Russell B. Arnold</u>		DATE SIGNED <u>4 May 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - May 6 1955</u>		NAME OF CEMETERY OR CREMATORY <u>City of St. George</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4 1955</u>		24. FUNERAL DIRECTOR <u>J. Arthur Dadds, 254 Carroll St. No. 12</u>	

BUENOS AIRES

MAY 6 1900

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4832

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04814

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR TOWN
<u>TOWN Kensington</u>		<u>Kensington</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4101 Knowles Ave.</u>		STREET ADDRESS <u>4101 Knowles Ave.</u> (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
<u>HERBERT NEWTON KEENE, JR.</u>		<u>May 19, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 70</u> yrs. <u>9</u> Months <u>10</u> Days <u>18</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:	
<u>Ret. Architect Self Emp.</u>		<u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>US</u>		<u>US</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Herbert N. Keene, Sr.</u>		<u>Laura Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:		<u>10414 Parkwood Dr. Kensington, D.C.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) ... <u>Coronary occlusion</u> DUE TO			<u>Sudden death</u>
Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
<u>Frank J. Broecker</u>		<u>5-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Glenwood</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
<u>5/21/55</u>		<u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Robert A. Campbell</u>		<u>Ed. Hesda, D.C.</u>	

BUREAU V. B.

MAY 24 1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04815
4762 CERTIFICATE OF DEATH Reg. Dist. No. 22.3

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Hash, D.C.</i>		COUNTY <i>4</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
17 TOWN <i>Takoma Park</i>		5 days		<i>Washington, D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
75 <i>Washington Sanitarium</i>				<i>211 Webster Street.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Edward Carlton King</i>				<i>May 27 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>4-25-02</i>	<i>53 yrs.</i>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>cab driver</i>						<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Edward C. King</i>				<i>Nonie Lydard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>No</i>						<i>Admission Record Hash. Sanitarium</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Acute Coronary Occlusion</i>						<i>1 hour</i>	
ANTECEDENT CAUSE (B) <i>Atherosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>5/9/55</i>		<i>Segmental occlusion of left iliac artery</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>5/8/55</i> , 19... to <i>5/27</i> ..., 19... that I last saw the deceased alive on <i>5/27</i> ..., 19... and that death occurred at <i>945A.M.</i> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Lytle Adellman</i>		<i>M.D. 8700 Colonsville Rd Silver Spring</i>		<i>5/27/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>May 30 1955</i>		<i>Salem Cedar Grove</i>		<i>Cedar Grove Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 27-1955</i>		<i>J. Wilma Reed</i>		<i>Ray W. Barber</i>		<i>Laytonville Md.</i>	

ROMULO V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04816

4763

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>TAKOMA PARK</u>		1 YR		OR TOWN <u>BALTIMORE MD.</u>		3V014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7311- MAPLE AVE</u>				STREET ADDRESS (If rural give location) <u>3705 TOWANDA AVE</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <u>FANNIE LEAH KOMINETSKY</u>				<u>MAY 21 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>FEB 10, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? ✓	
<u>HOUSEWIFE</u>				<u>RUSSIA</u>		<u>RUSSIA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>HYMAN BUPOWSKY</u>				<u>MANNIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>NO</u>						<u>CLARA SCHWARTZ 7311 MAPLE AVE F.P. MD.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>							<u>10 min.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>							<u>1 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 1954, to May 21, 1955, that I last saw the deceased alive on May 21, 1955, and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Simon C. Weiner</u>		ADDRESS <u>M.D. 100 Longfellow St NW</u>		DATE SIGNED <u>May 21, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-22-1955</u>		<u>MT. CARMEL</u>		<u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>MAY 22 1955</u>		<u>Simon C. Weiner</u>		<u>Dark Leurs Inc - 2100 Eutaw PL</u>			

RECEIVED
MAY 24 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

CERTIFICATE OF DEATH

Reg. Dist. No.

04817

216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Green Acres</u>	<u>17 yrs</u>	OR TOWN <u>Green Acres</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4922 Redford Rd</u>		STREET ADDRESS (If rural give location)	<u>4922 Redford Rd</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
NAME OF DECEASED: (Type or Print) <u>Wilson Norris Krahnke</u>		DATE OF DEATH: <u>5</u> <u>14</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct 14, 1906</u>
9. AGE last birthday: <u>48</u> yrs		10. BIRTHPLACE (State or foreign country): <u>North Carolina</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ferdinand H. Krahnke</u>		14. MOTHER'S MAIDEN NAME: <u>Clara Etta Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>No</u>		16. SOCIAL SECURITY NO <u>579-03-1533</u>	
17. INFORMANT & ADDRESS: <u>Catharine Krahnke Green Acres Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>152X</u>		<u>2 1/2 mos.</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Carcinoma of large & small intestine</u>			
(B) <u>—</u>			
(C) <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Mar. 1 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Inoperable carcinoma of large & small intestine</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. TIME (Month) (Day) (Year) (Hour) OF INJURY		21D. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1945, to <u>May 14</u> , 1955, that I last saw the deceased alive on <u>May 13</u> , 1955, and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Richard V. Mattingly</u>		ADDRESS <u>M.D. 4707 Corn. Ave. NW</u>	
DATE SIGNED <u>5/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Partial - Transit</u>		DATE THEREOF <u>5-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/17/55</u>		REGISTRAR'S SIGNATURE <u>Bernice M. Thompson</u>	
24. FUNERAL DIRECTOR <u>S. H. Henico Co.</u>		ADDRESS <u>Washington D.C.</u>	

BUREAU OF

MAY 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4834 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04818
 Items 8,9: film G181 5-23-55 **CERTIFICATE OF DEATH** Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN Bethesda Rural		1 mo 4 days		OR TOWN Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 2406 Dexter Avenue			
3. NAME OF DECEASED: (First) Lynnwood (Middle) Agustin (Last) KUHN				4. DATE (Month) (Day) (Year) OF DEATH May 18 1955			
5. SEX. Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 11-15-1915	
				9. AGE last birthday 39 3/4 yrs		10. IF UNDER 1 YEAR: Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator				10B. KIND OF BUSINESS OR INDUSTRY: Self Employed			
11. BIRTHPLACE (State or foreign country): Pennsylvania				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME: John B. KUHN				14. MOTHER'S MAIDEN NAME: Grace GRUNINGER			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. Same as above			
17. I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Malignant melanoma, multiple metastases				INTERVAL BETWEEN ONSET AND DEATH 7 months			
ANTECEDENT CAUSE (B) Malignant melanoma, left shoulder				3 years.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 14 Apr , 19 55 , to 18 May , 19 55 , that I last saw the deceased 18 May , 19 55 , and that death occurred at 1:55A M, from the causes and on the date stated above.							
SIGNATURE E. P. THELEN				ADDRESS DATE SIGNED			
E. P. THELEN LCDR MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		20 May 1955		Parklawn Cemetery Rockville Pike, Rockville, Maryland			
DATE REC'D BY LOCAL REGISTRAR 18 May 1955		REGISTRAR'S SIGNATURE Mary E. Carrelly		24. FUNERAL DIRECTOR Chevy Chase Funer. Home		ADDRESS 5103 Wisconsin Ave., N.W. Washington, D.C.	

BUREAU V. S.

MAY 23 1955

RECEIVED

4835

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Olney</u>		12hrs. 40 min.		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
22 The Montgomery County General Hospital, Inc.				R#2 Peach Orchard Road			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
DECEASED: (Type or Print) <u>Joseph Ernest Leizear</u>		OF DEATH: <u>May 8 1955</u>		<u>male</u>		<u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:		9. AGE last birthday		IF UNDER 1 YEAR Months Days	
<u>married</u>		<u>August 3/1873</u>		<u>81</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>painter</u>		<u>Own business</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Leizear</u>				<u>Sarah Catherine Colbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				<u>579-09-0351</u>		<u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Secondary Anemia</u>							
ANTECEDENT CAUSE (S) (B) <u>Carcinoma Bladder</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>L</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>✓</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/6/</u> ..., 19 <u>55</u> , to <u>5/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/3/</u> ..., 19 <u>55</u> and that death occurred at <u>3:50</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>5/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/10/55</u>		<u>Union Cemetery</u>		<u>Burtonsville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-12-55</u>		<u>[Signature]</u>		<u>Warner E. Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. V. S.

MAY 17

1964

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4836

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04820

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH.		2 USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8606 Cedar Street</u>	MARYLAND LENGTH OF STAY (in this place) <u>18 yrs</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> STREET ADDRESS (If rural give location) <u>8606 Cedar Street</u>	
3 NAME OF DECEASED: (First) <u>Alice</u> (Middle) <u>Mary</u> (Last) <u>Leonard</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>21</u> <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>9/11/70</u>
9. AGE last birthday <u>84</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William B. Boler</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen B. Grogan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Margaret M. Tuhy, 8606 Cedar Street Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Decompanaction</u>		<u>6-8 yrs</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Atherosclerosis</u>		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>		<u>?</u>	
19A. DATE OF OPERATION. <u>11</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1947</u> to <u>2/18</u> , 1955 that I last saw the deceased alive on <u>21 May</u> , 1955, and that death occurred at <u>3 P</u> M. from the causes and on the date stated above.			
SIGNATURE <u>William E. Boler</u>		DATE SIGNED <u>5/24/55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Trans. & Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	
DATE THEREOF <u>5/24/55</u>		LOCATION (City, town, or county) (State) <u>Oakland, Massachusetts</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Frances Boler</u>	
24. FUNERAL DIRECTOR <u>Warner L. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4837 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

04821

Item 18 Film G182 5-27-55 **CERTIFICATE OF DEATH**

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Tt Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Tt Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>56</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				<u>803 Hale Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Miss Illing P. Loeschke</u>				<u>May 10 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE MARRIED WIDOWED, DIVORCED (Specify):		8. DATE OF BIRTH: <u>July 9, 1900</u>	
9. AGE last birthday <u>54</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Worker, Jr. High School</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>			
13. FATHER'S NAME: <u>Paul Loeschke</u>				14. MOTHER'S MAIDEN NAME: <u>Wilhelmina Booker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-32-2458</u>		17. INFORMANT & ADDRESS: <u>Elmer F. Reddicov, Baltimore, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
223X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>						<u>2 hours</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Septicemia, Pilon (believed to be a Meningioma)</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Craniotomy for Brain Tumor</u>						<u>4 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Alcoholism, nervous obstruction</u>						<u>2 hours</u>	
19A. DATE OF OPERATION: <u>May 6, 1955</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 24</u> , 1953, to <u>10 May</u> , 1955 that I last saw the deceased alive on <u>10 May</u> , 1955, and that death occurred at <u>4:17 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ernest E. Harmon</u>				ADDRESS <u>9301 Calverville Rd Silver Spring Md</u>		DATE SIGNED <u>19 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/17/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Horn</u>		24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED
MAY 11 1964
BUREAU 4 3

4764

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) RURAL LENGTH OF STAY (in this place) 15 months
 OR TOWN Takoma Park
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 8 Lee Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) RURAL
 OR TOWN Takoma Park
 STREET ADDRESS (If rural, give location) 8 Lee Avenue

3. NAME OF DECEASED: (First) Elizabeth

(Middle)

(Last) Mac Innis4. DATE OF DEATH: (Month) May (Day) 13 (Year) 19555. SEX: Female6. COLOR OR RACE: Caucasian7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed8. DATE OF BIRTH: Aug. 19 18799. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife10b. KIND OF BUSINESS OR INDUSTRY: Home11. BIRTHPLACE (State or foreign country): Nova Scotia12. CITIZEN OF WHAT COUNTRY? U.S.A.13. FATHER'S NAME: Peter C. Mac Innis14. MOTHER'S MAIDEN NAME: Sarah Gillis15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No16. SOCIAL SECURITY No.: None17. INFORMANT & ADDRESS: Frank R. Mac Innis, 8 Lee Ave., Takoma Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0

Immediate cause

(a) DUE TO Inanition, decubitus ulcersINTERVAL BETWEEN ONSET AND DEATH 2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO Arteriosclerotic heart disease3 yrs(c) DUE TO Generalized arteriosclerosis1/3 yrs

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death. a. Rheumatoid arthritis, severe
b. Senility20. AUTOPSY? Yes ☐ No ☒

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/27/1952, to 5/13/1955, that I last saw the deceased alive on May 3, 1955, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 10 1907

1851
100-1000

4838

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural	LENGTH OF STAY (In this place) 2 Days	CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda	TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 8300 Wisconsin Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) Victor Wayne MARSH		4. DATE (Month) (Day) (Year) OF DEATH: May 2 1955	
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 11-30-54
9. AGE last birthday 5 yrs 5 Months 2 Days		10. IF UNDER 1 YEAR: 2 Hours 0 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant		10B. KIND OF BUSINESS OR INDUSTRY: Not Applicable	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Walter J. MARSH		14. MOTHER'S MAIDEN NAME: LINTHICUM, Suzanne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Walter J. MARSH (Father) Same as above			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pneumonia, lobar, left lung			48 hrs
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 30 April 1955 to 2 May , 1955 that I last saw the deceased live on 2 May , 1955, and that death occurred at 10:20 AM , from the causes and on the date stated above.			
SIGNATURE D. J. PASCOE LT, MC, USN		ADDRESS M. D USNH, NNMC, Bethesda, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 5-6-54	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Walter J. Marsh	24. FUNERAL DIRECTOR B. A. Pumphrey	
		ADDRESS Funeral Home 8357 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVE FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4839

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04824

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>		RURAL LENGTH OF STAY (in this place) <u>1 hr.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Barnesville</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Caroline</u>		(First) <u>Marie</u>		(Middle) <u>Mayhew</u>		(Last)	
4. DATE OF DEATH <u>May 5 1955</u>		(Month) <u>May</u>		(Day) <u>5</u>		(Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. SINGLE OR MARRIED: <u>Single</u>		7. WIDOWED, DIVORCED, OR		8. DATE OF BIRTH: <u>4/18/49</u>	
9. AGE last birthday: <u>6</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>School Student</u>		11. BIRTHPLACE (State or foreign country): <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Francis Mayhew</u>				14. MOTHER'S MAIDEN NAME: <u>Mattie Ward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY No.: <u>None</u>			
17. INFORMANT & ADDRESS: <u>Francis Mayhew - Barnesville, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Shock + bleed abdominal hemorrhage</u>						<u>1 1/2 hrs.</u>	
Antecedent cause(s) (b) <u>Rupture of hepatic, spleen both kidneys</u>						<u>1 1/2 hrs.</u>	
DUE TO (c) <u>Auto accident</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>5/8/55</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>		21c. (City or town) (County) (State) <u>Barnesville Montg Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Crossed highway in front of approaching car</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Franz J. Birscht</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-6-55</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Park</u>		LOCATION (City, town, or county) (State) <u>Bethesda Md</u>	
DATE REC'D BY LOCAL REG. <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>		24. FUNERAL DIRECTOR <u>William B. Hillen</u> ADDRESS <u>Barnesville, Md</u>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04825

4840

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shippensburg</u>			
X TOWN <u>Bethesda</u>		<u>23 days</u>		STREET ADDRESS (If rural give location) <u>R.D. #3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Ann M. McCormick</u>				<u>May 20 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>F</u>	<u>W</u>	<u>Single</u>	<u>19 June 1950</u>	<u>4 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John P. McCormick</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Kane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7244 IMMEDIATE CAUSE (A) <u>Chronic heart failure</u>							
ANTECEDENT CAUSE (S) (B) <u>Congenital cyanotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Pulmonary valve stenosis and patent foramen ovale</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>splenic infarction</u>							
19A. DATE OF OPERATION: <u>May 20, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Pulmonary stenosis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>--</u>		21C. WHERE DID INJURY OCCUR? <u>--</u>		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M. --</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>April 27, 1955</u> to <u>May 20, 1955</u> , that I last saw the deceased alive on <u>May 20, 1955</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>		DATE SIGNED <u>5/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Pittston</u>		LOCATION (City, town, or county) (State) <u>Pittston, Pa. Penna</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 22 1904

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4765
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04826
Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Takoma Park</u>		<u>80A</u>		TOWN <u>Takoma Park</u>		<u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. + Hosp.</u>				STREET ADDRESS (If rural, give location) <u>7310 Willow Ave</u>			
3. NAME OF DECEASED: (Type or Print) <u>Charles Leonard McCormick</u>				4. DATE OF DEATH <u>May 31</u> 19 <u>55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>April 18, 1955</u>	
9. AGE last birthday: <u>6 weeks</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Takoma Park, Md.</u>	
13. FATHER'S NAME: <u>Mr Charles J McCormick</u>				14. MOTHER'S MAIDEN NAME: <u>Corinne Ruth Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						?	
491X Immediate cause (a) <u>Broncho-pneumonia</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, or street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosehart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-31-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>6-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bellevue Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
DATE REC'D BY LOCAL REG. <u>May 31 1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Doff</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>			

100-10000

10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04827

4841

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
TOWN <u>Bethesda</u>				TOWN <u>Hyattsville</u> <u>1615-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location) <u>5902 36th Ave.</u> ✓			
3. NAME OF DECEASED: (First) <u>Arthur</u> (Middle) <u>Leo</u> (Last) <u>McWilliamson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>9</u> <u>1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5/26/47</u>	9. AGE last birthday <u>7</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ernest McWilliamson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Goode</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>--</u> (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage, base of brain</u>							
ANTECEDENT CAUSE (B) <u>Pulmonary edema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypersplenism and liver necrosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypersplenism and liver necrosis</u>							
19A. DATE OF OPERATION: <u>-- 72</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 2, 1955</u> , to <u>May 9, 1955</u> , that I last saw the deceased alive on <u>May 9 1955</u> , and that death occurred at <u>8:30 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Jarrett</u>		M.D. <u>The Clinical Center Natl. Institutes of Health</u>		DATE SIGNED <u>5/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5-12-55</u>		DATE THEREOF <u>5-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Washington, D.C.</u>		LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>1st Funeral Home</u>		ADDRESS <u>300 1st St. N.E. Wash. D.C.</u>	

BUREAU V. S.

MAY 11

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4766 CERTIFICATE OF DEATH

04828

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>6 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	<u>17</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural give location) <u>808 Houston Ave.</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>French Sterling Meadows</u>		<u>5 - 22 1955</u>	
5. SEX. <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH: <u>9-24-89</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Alabama</u>	
11. BIRTHPLACE (State or foreign country): <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Sterling Meadows</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Mayfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute anterior coronary thrombosis</u>		<u>9 days</u>	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>		<u>-</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Diabetes mellitus</u>		<u>-</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis obliterans of lower extremities</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13, 1955</u> , to <u>May 22, 1955</u> , that I last saw the deceased alive on <u>May 22, 1955</u> , and that death occurred at <u>5:25</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Sudrey Leventhal, M.D.</u>		ADDRESS <u>575 N. ...</u>	
DATE SIGNED <u>May 22, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		LOCATION (City, town, or county) (State) <u>Prince George's Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 22-1955</u>		REGISTRAR'S SIGNATURE <u>J. William Dodd</u>	
24. FUNERAL DIRECTOR <u>W. H. ...</u>		ADDRESS <u>875 ...</u>	

BUREAU V. S.

MAY 24 1955

RECEIVED

4767

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> OR TOWN <u>Takoma Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hosp.</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>Bethesda</u> STREET ADDRESS (If rural give location) <u>4807 Hampden Lane</u>		
3. NAME OF DECEASED: (Type or Print) <u>Flavia</u> (First) <u>H</u> (Middle) <u>Moise</u> (Last)			4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>29</u> <u>1955</u>		
5. SEX. <u>female</u>	6. COLOR OR RACE: <u>white american</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH: <u>May-12-1890</u>		9. AGE last birthday <u>65</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Charles H. Hungerford</u>			14. MOTHER'S MAIDEN NAME: <u>Amx J. Smith</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			17. INFORMANT & ADDRESS: <u>Wash. San. & Hosp. records</u>		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
1. IMMEDIATE CAUSE (A) <u>Malignant Lymphoma</u>					<u>6 years</u>
2. ANTECEDENT CAUSE (B) DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/27/1955</u> , to <u>5/29/1955</u> , that I last saw the deceased alive on <u>5/27/1955</u> , and that death occurred at <u>7A</u> M; from the causes and on the date stated above.					
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>burial</u>		DATE THEREOF <u>6-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Congressional Ave 4th & 5th St. N.E.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May-29-55</u>		REGISTRAR'S SIGNATURE <u>J. W. McDonald</u>		24. FUNERAL DIRECTOR ADDRESS <u>R. C. Pumphrey Bethesda Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1944

1944

1944

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04830

4842

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>74</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Green Echo</u> STREET ADDRESS (If rural give location) <u>104 - Cassard Circle</u>	
3. NAME OF DECEASED: (Type or Print) <u>Medrie Thomas Money</u> (First) (Middle) (Last)		4. DATE OF DEATH: <u>May 29</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>May 2, 1894</u> 9. AGE last birthday: <u>61</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Washington D.C.</u>	
11. FATHER'S NAME: <u>Thomas Randolph Money</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		14. SOCIAL SECURITY NO. <u>316-15th St. E.</u>	
15. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u> DUE TO ANTECEDENT CAUSE (B) <u>cerebral arteriosclerosis</u> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <u>37 hours</u> <u>undetermined</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-27</u> 19 <u>55</u> , to <u>5-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above. SIGNATURE <u>John L. Lippert, M.D.</u> ADDRESS <u>1001 Spring Hill Dr. N.W.</u> DATE SIGNED <u>5-29-55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/1/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, or county) (State) <u>Switland Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/1/55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>		ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u>	

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4843 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04831

CERTIFICATE OF DEATH

Reg. Dist. No. 276

Form 7, Film 0151, 5/11/55

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>104 Vassar Circle</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mrs. Ella R. Titoney</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1/19/92</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u>	IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington DC,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>E. Klein</u>				14. MOTHER'S M.A.DEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Cedric T. Money</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>						4 days	
ANTECEDENT CAUSE (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (M.)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>4/30</u> , 1955, to <u>5/3</u> , 1955, that I last saw the deceased alive on <u>5/2</u> , 1955, and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. L. Marks M.D.</u>		ADDRESS <u>M.D. 6306 Wisconsin Ave N.W., Wash. D.C.</u>		DATE SIGNED <u>5/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, of county) (State) <u>Suitland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>		ADDRESS <u>3072-14 - 18 NW, Wash. D.C.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04832

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>SAME</u> COUNTY <u>Rockville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>13205 Ardennes Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Anna Justine Mooney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 20, 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 17, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>93</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>BERWICK PA.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON Sittler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth De Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Thelma Mooney</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardio-respiratory Failure</u>		<u>30'</u>
Antecedent cause(s) (b) <u>myocardial Infarction</u>		<u>6 mos</u>
(c) <u>coronary arteriosclerosis</u>		<u>Indefinite</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/2/1954, to 5/20/1955, that I last saw the deceased alive on 5/20/1955, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-22-55</u>	<u>Pine Grove Cemetery</u>	<u>BERWICK PA.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-22-55</u>	<u>Lawell H. Taylor</u>	<u>W.W. Chambers</u>	<u>3072 M. St. NW.</u>	

MARGIN RESERVE FOR FINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. P.

10/10/10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#8. Film 181 5/17/55 1st

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

048336

4844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Virginia</u> COUNTY <u>Norfolk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Norfolk</u>		STREET ADDRESS (If rural give location) <u>210 East Randall Ave.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>49 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Norfolk</u>		STREET ADDRESS (If rural give location) <u>210 East Randall Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 East Randall Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Edward Moran</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>5 - 3 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>11-4-88</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired printer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired printer</u>		9. AGE last birthday <u>66</u> yrs		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
13. FATHER'S NAME: <u>John Moran</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Clements</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Abelarde P. Moran - wife</u> <u>210 East Randall Ave. Norfolk, Va.</u>			
16. SOCIAL SECURITY NO. <u></u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I' DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Decompression</u>							
ANTECEDENT CAUSE (B) <u>Hypertensive Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Old focal encephalomalacia due to hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old focal encephalomalacia due to hypertension</u>							
19A. DATE OF OPERATION: <u>5-1-55</u>				19B. MAJOR FINDINGS OF OPERATION: <u></u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u></u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>5-1-55</u> , 19 <u>55</u> , to <u>5-3-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-3-55</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Thibodeau</u>				M. D. <u>Kenneth L. ...</u>		DATE SIGNED <u>5-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 9 1955</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>F. Pasch's Sons</u>		ADDRESS <u>Hyattonville Md.</u>	

BUNNY W. E.

10 June

10/10/10

4845

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Cedar Grove</u>		
<u>X</u> TOWN <u>Olney</u>	<u>2 days</u>		STREET ADDRESS (If rural give location)	<u>R.F.D. #1 Germantown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen'l Hosp.</u>					
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH:	(Month) (Day) (Year)
(Type or Print)	<u>Samuel</u>	<u>Eugene</u>	<u>Mullinix</u>	<u>5/8/55</u>	<u>19</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
<u>male</u>	<u>white</u>	<u>married</u>	<u>1/26/15</u>	<u>40</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Saw Mill & Threshing</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Samuel E. Mullinix</u>			14. MOTHER'S MAIDEN NAME: <u>Elsie Moxley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-26-9128</u>		
17. INFORMANT & ADDRESS: <u>Hospital records</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Gastro-intestinal hemorrhage</u>		<u>60 hours</u>
ANTECEDENT CAUSE (B) <u>Metastatic melanoma of liver</u>		<u>2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Melanoma (malignant) retina left eye</u>		<u>2½-3 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10/..., 1955, to 5/8..., 1955, that I last saw the deceased alive on May 8, 1955, and that death occurred at 5:07PM, from the causes and on the date stated above.

SIGNATURE <u>Olin J. Molesworth</u>	ADDRESS <u>Damascus, Md.</u>	DATE SIGNED <u>May 8, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>May 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Salem</u>
		LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>5-9-55</u>	REGISTRAR'S SIGNATURE <u>Arthur B. Lavelle</u>	24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>
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MARGIN RESERVED FOR BINDING

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04835

4846

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7108 Exfair Rd</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> STREET ADDRESS (If rural give location) <u>7108 Exfair Rd</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Peter T. Murphy</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> <u>31</u> <u>19 55</u>				
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>April 17, 1865</u>		9. AGE last birthday: <u>90</u> yrs IF UNDER 1 YEAR: <u>1</u> Months <u>14</u> Days IF UNDER 24 HRS.: <u>14</u> Hours <u>14</u> Min		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country): <u>Ireland</u>			
13. FATHER'S NAME: <u>Terence Murphy</u>			14. MOTHER'S MAIDEN NAME: <u>Ellen Traynor</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Margaret Collins</u> <u>7108 Exfair Rd. Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arterio sclerotic Heart Disease</u>					<u>6 yrs</u>		
ANTECEDENT CAUSE (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>May 20, 1953</u> , to <u>May 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>55</u> , and that death occurred at <u>5:20</u> M, from the causes and on the date stated above. SIGNATURE <u>P. J. Brennan</u> M.D. <u>Bethesda</u> ADDRESS <u>—</u> DATE SIGNED <u>5-31-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>			
LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>					
DATE REC'D BY LOCAL REGISTRAR <u>6/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Thompson</u>			

RECEIVED

JUN 2 1955

U. S. BUREAU

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4768

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

04836

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>21 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	<u>56</u>
TOWN <u>Washington Sanitarium & Hospital</u>		OR TOWN <u>715 Ritchie Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>5-24-1955</u>	
<u>Julia Margaret Nasella</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>9-11-80</u>
9. AGE last birthday: <u>74</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hsuf.</u>	11. BIRTHPLACE (State or foreign country): <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hsuf.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
13. FATHER'S NAME: <u>JAMES Dugan</u>		14. MOTHER'S MAIDEN NAME: <u>Hanara Doyle</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FOREST (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>332X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>Pulmonary & Cerebral Infarction</u>		<u>3 wks</u>	
(B) <u>Pulmonary Thromboses</u>		<u>3 wks</u>	
(C) <u>Rt. Posterior Cerebral artery "</u>		<u>3 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>		<u>3 wks</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15, 1954</u> , to <u>May 24, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>4:40 P M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Samuel J. Dugan</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
DATE THEREOF <u>5/27/55</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 26 1955</u>		24. FUNERAL DIRECTOR <u>Walter L. Humphrey</u>	
REGISTRAR'S SIGNATURE <u>William D. Dadd</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01103 Dpt. No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>P. G.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
26 TOWN <i>Rockville</i>		<i>3 mo</i>		<i>mt. Rainier</i>		<i>15-1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>702 Beall Ave</i>				STREET ADDRESS (If rural, give location) <i>3407 Newton St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Eleanor Gallagher Nicholson</i>				<i>May 27 1955</i>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>Female</i>		<i>White</i>		<i>Married</i>		<i>8-2-'99</i>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>57</i>		<i>Medical nursing</i>				<i>md.</i>	
12. CITIZEN OF WHAT COUNTRY?				<i>U.S.</i>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>No</i>		<i>Unknown</i>		<i>Naomi Nicholson - Room 212</i>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <i>Coronary occlusion</i>						<i>Sudden death</i>	
DUE TO							
Antecedent cause(s) (b) <i>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</i>							
DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<i>0</i>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <i>Donald J. Bruchart</i>				M. D. ASSISTANT MEDICAL EXAM. <i>5-27-55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5-31-55</i>		<i>Parklawn</i>		<i>Rockville, Maryland</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		GENERAL DIRECTOR		ADDRESS	
<i>5/31/55</i>		<i>Lawell H. Bruchart</i>		<i>Robert A. Humphrey</i>		<i>1000 ...</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 018383

4769

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
OR TOWN <u>T. Koma Park, md</u>		<u>3 days</u>		OR TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Washington San & Hospital</u>				<u>813 Bonifant St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>William Perry Nixon</u>				<u>May 27 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>3-26-95</u>	
9. AGE last birthday IF UNDER 1 YEAR: <u>60 yrs</u>		IF UNDER 24 MRS. Months Days Hours Min					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Loan Spec. Dept. Agric.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>John A. Nixon</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann Perry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <u>W. W. I.</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Thelma C. Nelson - Silver Spring</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebro</u>						<u>3 months</u>	
ANTECEDENT CAUSE (B) <u>Pulmonary Emboli</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1951, to <u>May 27</u> , 1955, that I last saw the deceased alive on <u>May 26</u> , 1955, and that death occurred at <u>1:30 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. W. I.</u>		ADDRESS <u>M. D. 837 Boulevard Avenue Spring Md.</u>		DATE SIGNED <u>5/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		LOCATION (City, town, or county) (State) <u>Petersville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/2/55</u>		REGISTRAR'S SIGNATURE <u>Laurel G. Knapton</u>		24. FUNERAL DIRECTOR <u>C. H. Felt & Bro</u>		ADDRESS <u>Brunswick Md.</u>	

S. A. 1171007

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04839

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Richmond Avenue</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>Silver Spring</u> STREET ADDRESS <u>815 Richmond Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Sallie</u> (First) <u>Ann</u> (Middle) <u>Palmer</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 16, 1872</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton A. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Eliza A. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Barber C. Palmer, Silver Spring, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
142X Immediate cause (a) <u>Pneumonitis - Pulmonary Edema</u>		<u>15 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chronic myocarditis - hypertension - cardiovascular-renal disease.</u>		<u>15 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>33</u> , to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>E. A. Krause M.D.</u>		ADDRESS <u>3805 McKinley St. N.W., Wash. 15, D.C.</u> DATE SIGNED <u>May 25, 1955.</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/28/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BOWEN V. B.

1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Hills Texaco Service Station</u>				STREET ADDRESS (If rural, give location) <u>9402 Warren Street</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Fred</u>		(Middle) <u>Daniel</u>		(Last) <u>Pence</u>	
4. DATE OF DEATH		(Month) <u>May</u>		(Day) <u>19</u>		(Year) <u>1955</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 9, 1898</u>	
9. AGE last birthday <u>56</u> yrs.		If under 1 year Months <u> </u> Days <u> </u>		If under 24 hrs. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Owner of a Filling Station</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Edinburg, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Pence</u>				14. MOTHER'S MAIDEN NAME <u>Lilli Summers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT AND ADDRESS <u>Mr. Fred J. Pence, 9402 Warren St.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u>						<u>Sudden death</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brontfort M.D.</u>		(Degree or title)		ADDRESS <u>Gaithersburg Md</u>		DATE SIGNED <u>5-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. & Burial</u>		DATE THEREOF <u>5/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hawkinstown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Shenandoah County, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>may 23/55 Frances Potter</u>				24. FUNERAL DIRECTOR <u>Walter E. Humphrey</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04841

Reg. Dist. No. 211

4849

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ST. MARY'S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PANAMA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW WINDSOR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>P</u> (Last) <u>Good</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-23-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>	9. AGE last birthday <u>78</u> yrs. If under 1 year: Months <u>7</u> Days <u>12</u> Hours <u>19</u> Min. <u>45</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN P. GOOD</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CARROLL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. STANLEY WAGNER, PANAMA, MARYLAND</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>	<u>5 hours</u>
Antecedent cause(s) (b) <u>Arteriosclerotic or atherosclerotic disease</u>	<u>10 years</u>
(c) <u></u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u> (CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>	
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1955, to May 12, 1955, that I last saw the deceased alive on May 12, 1955, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>James S. Kern</u> (Degree or title) <u>M.D.</u> ADDRESS <u>Panama, Md.</u> DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> DATE THEREOF <u>5-15-1955</u> NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u> LOCATION (City, town, or county) <u>St. Mary's</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 12, 1955</u> REGISTRAR'S SIGNATURE <u>Della K. Burdette</u> FUNERAL DIRECTOR <u>Wm. L. Smith</u> ADDRESS <u>1114</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

THE A. C. C. C.

100

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04842

4850

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Arlington</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arlington</u> <u>83 X - 3</u>			
X TOWN <u>Bethesda Rural</u>		<u>3 days</u>		STREET ADDRESS (If rural give location) <u>2510 16th Street</u> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Janet Cook PORTER</u>				OF DEATH: <u>May 1 19 55</u>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday	10. UNDER 1 YEAR	11. UNDER 1 YEAR	12. UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>1-13-53</u>	<u>2 yrs.</u>	<u>Months</u>	<u>Days</u>	<u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert C. PORTER</u>				14. MOTHER'S MAIDEN NAME: <u>Sylvia CONANT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Father: Robert C. PORTER 2510 16th N. Arlington, Virginia</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral thromboembolism</u>						<u>1 day</u>	
ANTECEDENT CAUSE (S) <u>Subacute bacterial Endocarditis</u>						<u>2 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart Disease</u>						<u>27 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Apr.</u> , 1955, to <u>1 May.</u> , 1955, that I last saw the deceased alive on <u>1 May</u> , 1955, and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. S. ALLEN</u>		ADDRESS <u>MC USN U.S. Naval Hospital, NNMC, Bethesda, Md.</u>		DATE SIGNED <u>1 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5 May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-1-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>		24. FUNERAL DIRECTOR <u>IVES FUNERAL HOME</u>		ADDRESS <u>2847 Wilson Blvd. Arlington, Virginia</u>	

BUREAU V. S.

MAY 3

RECEIVED
MAY 3 1964

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4851

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04843

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 7, Film C181, 5/11/55

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs</u> 56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>11814 Kluggins Ln.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Mrs. Edith S. Rice</u>	(First) (Middle) (Last)	4. DATE OF DEATH: <u>May 6 1955</u>	(Month) (Day) (Year)
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4/13/92</u>
9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Woodruff</u>	14. MOTHER'S MAIDEN NAME: <u>Carter</u>	17. INFORMANT & ADDRESS: <u>Harry A. Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>171X</u> <u>Septicemia</u>			
ANTECEDENT CAUSE (B) <u>cerebral hemorrhage</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>total hysterectomy for bleeding April 29/55</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>carcinoma of cervix</u>			
19A. DATE OF OPERATION: <u>14/29/55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>bleeding uterus</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-15</u> , 19 <u>55</u> , to <u>5-6/55</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>55</u> and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John P. Ralston M.D.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		24. FUNERAL DIRECTOR <u>The S. N. Harris Co.</u> ADDRESS <u>2901 14th St. Washington, D.C.</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

BURTON & S.

CERTIFICATE OF DEATH

4852

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN, MD</u>	STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT. RAINIER</u> 16-1-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>INSTITUTION MARYLANDER</u>	LENGTH OF STAY (in this place) <u>4 1/2 YRS</u>	STREET ADDRESS (If rural give location) <u>4226 31st ST.</u>	
3. NAME OF DECEASED: (First) <u>HELEN</u> (Middle) <u>RICHARDS</u> (Last) <u>RICHARDS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 8 1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>FEB 13, 1865</u>
9. AGE last birthday: <u>90</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE IN OWN HOME</u>	11. BIRTHPLACE (State or foreign country): <u>CLARKSBURG, MD</u>	12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>
13. FATHER'S NAME: <u>G. W. MURPHY</u>		14. MOTHER'S MAIDEN NAME: <u>JULIA SHRIVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>HOME RECORDS</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>4221</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Intermittent cardiovascular disease</u>			<u>5 years</u>
(B) <u></u>			
(C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 9, 1955</u> , to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 3, 1955</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James P. Keen</u>		DATE SIGNED <u>May 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>5-8-55</u>	
NAME OF CEMETERY OR CREMATORY <u>MT. RAINIER, MD.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>May 12/55</u>		REGISTRAR'S SIGNATURE <u>Abraham S. Cooke</u>	
24. FUNERAL DIRECTOR <u>VALLEY'S FUNERAL HOME</u>		ADDRESS <u>3300 R.I. AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 10 1907

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4853

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04845

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Olney</u>		<u>1 day</u>		<u>Laytonsville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
73 <u>Montgomery County General Hospital, Inc.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Edward Francis Riordan</u>				<u>May 13 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>7/19/1866</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Blacksmith</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Daniel Riordan</u>				<u>Catherine Costello</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>						<u>9 hours</u>	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Heart Disease</u>						<u>Not known</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
		<u>Home</u>		<u>Laytonsville Mont. Md.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY:		21E. INJURY OCCURRED (While at work) (Not while at work)		21F. HOW DID INJURY OCCUR?			
<u>May 11 5 20 PM</u>		<u>While at work</u>		<u>Fell while reaching for recept.</u>			
22. I hereby certify that I attended the deceased from <u>May 11, 19 55</u> , to <u>May 13, 19 55</u> , that I last saw the deceased alive on <u>May 13, 19 55</u> , and that death occurred at <u>6:18 PM</u> from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Frank Schumacher</u>		<u>Dr. Smith</u>		<u>Smithsburg, Md.</u>		<u>May 14, 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 16 19 55</u>		<u>St. Peter's Church</u>		<u>Laytonsville</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-15-55</u>		<u>Arthur B. Fowler</u>		<u>127 11 12 26-27</u>		<u>Laytonsville</u>	

BUREAU OF

MAY 1960

100-100000-1

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Washington
 OR Takoma Park
 TOWN (in this place)

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Washington San. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Dist of Col. COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR Washington
 TOWN (If rural give location) 47X-3

STREET
 ADDRESS 228 Webster St., N.E.

3. NAME OF DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Rosenfield

4. DATE (Month) (Day) (Year)

OF DEATH

May 41955

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE MARRIED.

WIDOWED, DIVORCED.
(Specify):

8. DATE OF BIRTH

May 4, 1955

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 1 YEAR

IF UNDER 24 HRS.

IF UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

Milton Theodore Rosenfield

14. MOTHER'S MAIDEN NAME:

Sarah Blanche Yager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Y

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Mothers Chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X
IMMEDIATE CAUSE

DUE TO

prematurity (gestation 21 weeks)

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

While ☐ Not while ☐
at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-4 ... 1955, to 5-4, 1955, that I last saw the deceased

alive on 5-4, 1955, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 6 1955J. Wilson DoddR. A. Hare, M.D.Wash. San. Hosp.

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Written permission rec'd from both parents, Walter M.R.L.

BUCKINGHAM

1841

1841

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shower Spring</u> LENGTH OF STAY (in this place) <u>7 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shower Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1953 Seminary Rd.</u>		STREET ADDRESS (If rural, give location) <u>1953 Seminary Rd.</u>	
3. NAME OF DECEASED (First) <u>Emelia</u> (Middle) <u>Scherger</u> (Last) <u>Scherger</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 17 1865</u>
9. AGE last birthday <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Teacher</u>		14. MOTHER'S MAIDEN NAME <u>Bernadine Lehman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Miss B. Scherger</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>422.2 Cerebral embolism</u>	<u>1 day</u>
Antecedent cause(s) <u>The long myocarditis was probably giving rise to the above cause stating the underlying cause last</u>	<u>16 mo</u>
2. OTHER SIGNIFICANT CONDITIONS <u>Gen. interossions</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from 9/23/43, 1943, to 5/25/55, 1955, that I last saw the deceased alive on 5/24/55, 1955, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE <u>G. I. House</u>		ADDRESS <u>2030 Avenue Parkway Wash. D.C.</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
LOCATION (City, town, or county) <u>Washington</u>		(State) <u>D.C.</u>		24. FUNERAL DIRECTOR <u>—</u>	
DATE REC'D BY LOCAL REG. <u>May 22/55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		ADDRESS <u>254 Carroll St. N.Y.</u>	

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicist: please write the causes of death clearly and legibly.

GOVERNMENT V. S.

MAY 21

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04848

4855

CERTIFICATE OF DEATH

Reg. Dist. No. 2-14

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>3 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2700 Harris Avenue</u>		STREET ADDRESS (If rural give location) <u>2700 Harris Ave.</u>	<u>1</u>
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<u>Marshall Anderson Shaffer</u>		<u>May 25 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Nov. 24, 1899</u>
		9. AGE last birthday <u>55</u> yrs	10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>25</u> Hours <u>1</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Architect</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>	11. BIRTHPLACE (State or foreign country) <u>Hamilton - Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Leigh Shaffer</u>		14. MOTHER'S MAIDEN NAME: <u>Emily MacLean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service) <u>1945-55</u>		16. SOCIAL SECURITY NO. <u>1945-55</u>	
17. INFORMANT & ADDRESS: <u>Helen Shaffer - 2700 Harris</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Arrest</u>			
ANTECEDENT CAUSE (S) <u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>34 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None.</u>			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 24, 1955</u> to <u>May 25, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Joseph Stiel</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5/27/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>DC</i>		COUNTY <i>47X-3</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>17 TAKOMA PARK</i>		LENGTH OF STAY (in this place) <i>2 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Wash. Sanitarium</i>				STREET ADDRESS (If rural give location) <i>1413 Chatterdown St N.W.</i>			
3. NAME OF DECEASED: (First) <i>Mollie</i> (Middle) <i>Shapiro</i> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 31 1955</i>			
5. SEX. <i>7</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>?</i>	
9. AGE last birthday <i>72</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Rose</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>4/10</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Wash. San + Hosp Records</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebro Vascular Accident</i>				<i>hrs.</i>			
ANTECEDENT CAUSE (B) <i>Arteriosclerotic Hypertension</i>				<i>years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-16</i> , 1953 to <i>5-30</i> , 1955, that I last saw the deceased alive on <i>5-30</i> , 1955, and that death occurred at <i>5:25</i> A.M., from the causes and on the date stated above.							
SIGNATURE <i>Isidore Shulman</i>		ADDRESS <i>915-1944 N.W.</i>		DATE SIGNED <i>5-21-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5/31/55</i>		NAME OF CEMETERY OR CREMATORY <i>Bnei Israel Cemetery</i>		LOCATION (City, town, or county) (State) <i>Oxon Hill, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 31-1955</i>		REGISTRAR'S SIGNATURE <i>J. William Dodd</i>		24. FUNERAL DIRECTOR <i>B. Hanyansky</i>		ADDRESS <i>Son Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU 4/3

4856

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>--</u> COUNTY <u>--</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>26 days</u>		TOWN <u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>3541 Highwood Dr., S.E.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Effie</u>		(Middle) <u>Alma</u>		(Last) <u>Simmonds</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		8. DATE OF BIRTH: <u>March 17, 1904</u>		9. AGE last birthday: <u>51</u> yrs.	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>				10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>George Tavenner</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Franklin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-36-4785</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
16. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intrahepatic thrombosis of branch of portal vein</u>							
ANTECEDENT CAUSE (B) <u>Cancer of breast with metastases to liver, lungs, adrenals, retroperitoneal lymph nodes, and left carotid artery</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>--</u>				19B. MAJOR FINDINGS OF OPERATION: <u>--</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 20</u> , 1955, to <u>May 26</u> , 1955, that I last saw the deceased alive on <u>May 26</u> , 1955, and that death occurred at <u>6:45pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Alexander Breslow</u>				ADDRESS <u>The Clinical Center M.D. Natl. Institutes of Health</u>		DATE SIGNED <u>5/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Calmar Manor Spd.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Spattling</u>		ADDRESS <u>131-11 St. B.E. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

ROBERT A. B.

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04851

4857

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	TOWN
X TOWN <u>Bethesda</u>	<u>11 Days</u>	<u>Cherry Chase</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>74 Suburban</u>		<u>6900 Strathmore Street</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>May 11</u> <u>1955</u>	
(Type or Print) <u>William Alexander Smit</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 24, 1892</u>
			<u>62</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Real estate</u>		<u>Salesman</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<u>Mrs. Cleo Smit</u>		<u>6900 Strathmore St. Cherry Chase, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE			
(A) <u>Acute myocardial infarction</u>			
DUE TO			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>Thrombosis, left descending coronary artery</u>			
DUE TO			
(C) <u>Atherosclerosis, coronary</u>			
DUE TO			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:			
<u>and myocardial infarct.</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/11/55</u> to <u>5/11/55</u> , that I last saw the deceased alive on <u>5/11/55</u> , and that death occurred at <u>Cherry Chase, Md.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>George A. Gray, Jr.</u> M.D. <u>Cherry Chase, Md.</u> DATE SIGNED <u>5/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>5-10-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Arlington National</u>		<u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>5/14/55</u>		<u>Bennie M. Shaw</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Robert H. Humphrey</u>		<u>Bethesda, Md.</u>	

3 2 1120000

1 1 1120000

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Rural	LENGTH OF STAY (in this place) 3 mo 13 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fairfax	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 124 Fairview Drive	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) George	(Middle) Sanford	(Last) SMITH	OF DEATH: May 22 19 55
5. SEX. Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1-28-15
9. AGE last birthday: 40 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Manager		10B. KIND OF BUSINESS OR INDUSTRY: Gas Company	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William C. SMITH		14. MOTHER'S MAIDEN NAME: Agnes MALONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 217 10 2217	
(If Yes, give war or dates of service) WW II		17. INFORMANT'S ADDRESS: Wife Mrs. Eunice G. Smith Same as above	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Irreversible shock			5 days
ANTECEDENT CAUSE (B) Multiple fat emboli			5 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 17 May 55		19B. MAJOR FINDINGS OF OPERATION: Non union, prox at femur	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: on duty, aircraft	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? at sea off North Carolina Coast		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Nov 15 1954 M.	
21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? airplane crash	
22. I hereby certify that I attended the deceased from 22 May , 19 55 to 22 May , 19 55 that I last saw the deceased alive on 22 May , 19 55 , and that death occurred at 12:15A , from the causes and on the date stated above.			
SIGNATURE Robert G. Kindred		ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 25 May 1955	
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Cemetery		LOCATION (City, town, or county) (State) Wicomico Co, Maryland	
DATE REC'D BY LOCAL REGISTRAR 23 May 1955		REGISTRAR'S SIGNATURE Frank C. Parashy	
24. FUNERAL DIRECTOR R. A. Humphrey		ADDRESS Funeral Home 7557 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 20 1911

RECEIVED
MAY 20 1911

4859

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		1 day		OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>12611 Bushey Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Kendall Joseph SMITH</u>				<u>May 11 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-10-55</u>			<u>14</u>	<u>42</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME: <u>Floyd G. SMITH</u>				14. MOTHER'S MAIDEN NAME: <u>Ursula B. HAUSER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS: <u>Father Mr. Floyd G. SMITH Same as above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prematurity</u>							<u>15 hrs</u>
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 May, 1955</u> , to <u>11 May, 19 55</u> that I last saw the deceased <u>alive on 11 May, 19 55</u> , and that death occurred at <u>4:45AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>D. J. PASCOE</u> LT MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland				ADDRESS DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>16 May 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Vir ginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12 May 1955</u>		<u>Mary E. Sarnelly</u>		<u>H. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 - 10 - 53

2055342210

BUNEAU V. S.

1877

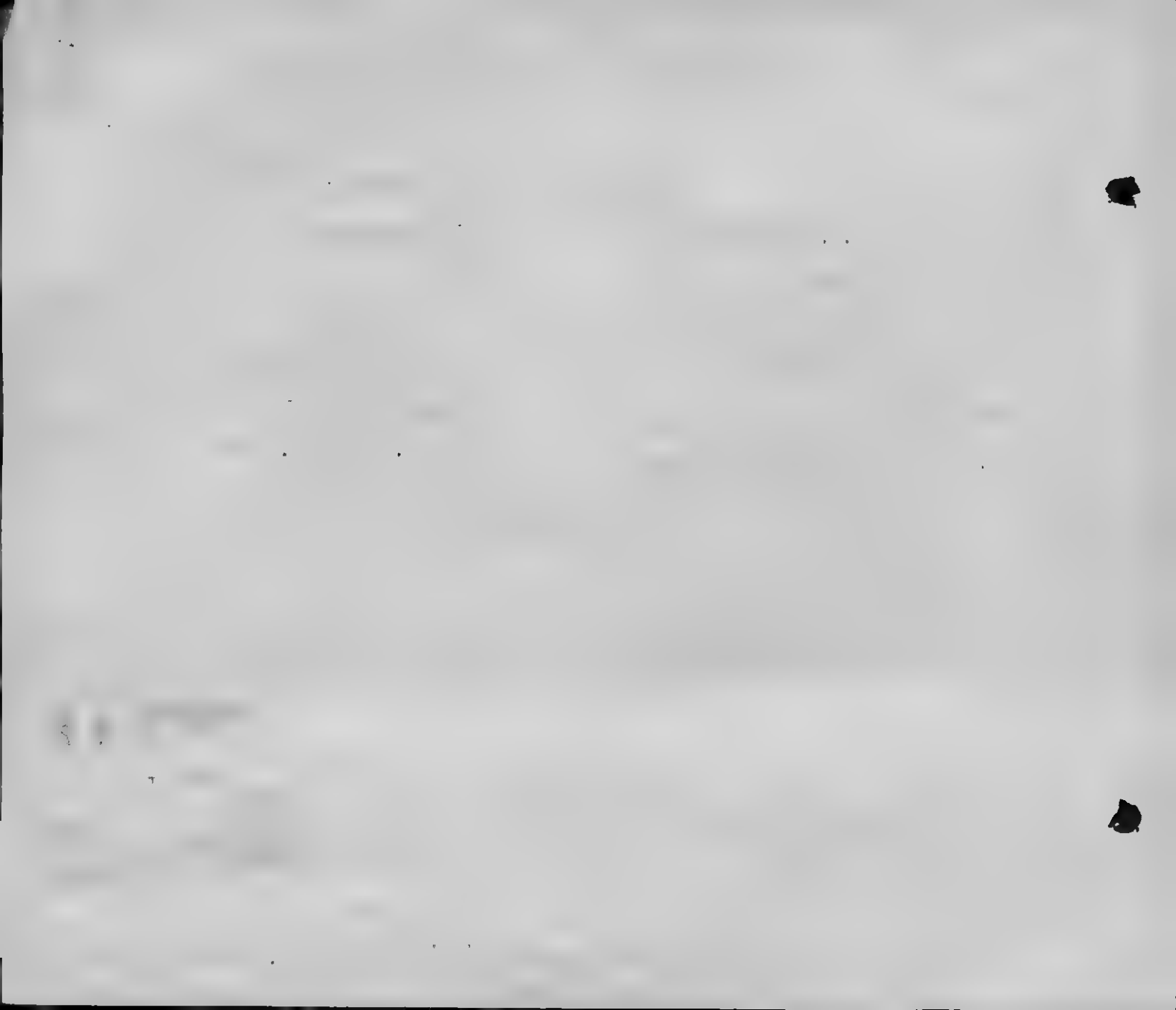
1877

1877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4860 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04854 Dist.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda (Rural)		LENGTH OF STAY (Specify): DOA (this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bethesda, Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital				STREET ADDRESS (If rural, give location) 7618 Clarendon Road			
3. NAME OF DECEASED: (Type or Print) Norman		(First) Truitt		(Last) SMITH		4. DATE OF DEATH (Month) May (Day) 26 (Year) 1955	
5. SEX: Male	6. COLOR OR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 3 Mar 97	9. AGE last birthday: 58 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Postal clerk			10b. KIND OF BUSINESS OR INDUSTRY: Retired	11. BIRTHPLACE (State or foreign country): Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: ANTHONY SMITH				14. MOTHER'S MAIDEN NAME: VIRGINIA SHIPLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Miriam O. SMITH Same as above			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) giving rise to the above cause stating underlying cause last DUE TO (c)						Immediate death	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE James J. Burchart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> 5-26-55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 31 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. 27 May 1955		REGISTRAR'S SIGNATURE Mary E. Parrelly		FUNERAL DIRECTOR R. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04855

4861

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Cherry Chase Md</u>		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Ch. Maryland</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>4709 Re Runsey Ph.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>MATILEH (N) SORGENFREY</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>5-26-55</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 6, 1880</u> 75 yrs.	
9. AGE last birthday: <u>75</u> yrs.				10. AGE last birthday: If UNDER 1 YEAR		If UNDER 24 HRS.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Henry Vierkamp</u>			
14. MOTHER'S MAIDEN NAME: <u>Sophie CLAUSSEN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 NO</u>			
16. SOCIAL SECURITY No.: <u>—</u>				17. INFORMANT & ADDRESS: <u>Linda Fletcher (Daughter)</u>			
18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 Immediate cause (a) DUE TO <u>Pneumonia</u>						5 days	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO <u>Coronary arteriosclerosis</u>						5 years	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>—</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 195 <u>9</u> , to <u>May 26</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>May 25</u> , 195 <u>5</u> , and that death occurred at <u>5 pm</u> <u>5/26/55</u> from the causes and on the date stated above.							
SIGNATURE <u>Roger D. Work</u>		(Degree or title) <u>M.D., 361 Sweetleaf Ave. N.W. Wash. D.C.</u>		DATE SIGNED <u>5-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Durant Cem.</u>		LOCATION (City, town, or county) (State) <u>Durant Cedar Co. Iowa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 Wisc. ave. N.W. Wash. D.C.</u>	

BUREAU V. S.

MAY 11 1964

RECEIVED

4862

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	District of Columbia	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	STATE COUNTY	
Bethesda - Rural	11 Hrs. 26 Min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
U.S. Naval Hospital	637 5th Street, N.E.		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
August Otto STARKE		May 5 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	Caucasian	Married	11-21-77
9. AGE last birthday		10. AGE last birthday	
77 yrs.		77 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
Civil Service US Govt		Retired	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Washington, D.C.		U. S.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Albert STARKE		Mary ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
Yes		Spanish American Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Wife Mrs. Lola Starke		Same as above	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		acute pulmonary edema	
ANTECEDENT CAUSE (S)		1 day.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Hypertensive cardiovascular disease	
(B)		unknown	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
M.		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5 May , 19 55 , to 5 May , 19 55 , that I last saw the deceased alive on 5 May , 19 55 , and that death occurred at 10:46 P M , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
C. S. STROUD		CDR MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
Burial 10 May		Arlington National Cemetery Arlington, V irginia	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
6 May 1955		Lee Funeral Home 4th and Mass Avenue, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 1910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4864

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04857
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>4 Hours</u>		TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural, give location) <u>6625 Bradley Blvd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Peter Frederick Stebbings</u>				<u>May 31 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Feb. 28, 1944</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>school</u>		9. AGE last birthday: <u>11</u> yrs. <u>3</u> months <u>3</u> days <u>3</u> hours <u>1</u> min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Stebbings</u>				14. MOTHER'S MAIDEN NAME: <u>Joan Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Mrs. Joan Stebbings 6625 Bradley Blvd, Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Abdominal hemorrhage due to rupture of liver</u>							
Antecedent cause(s) (b) <u>Subdural hemorrhage due to fracture of skull</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>fracture of both legs</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>street</u>		21c. (City or town) (County) (State) <u>Bethesda Monty Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-31-55-3:45-P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>struck by truck (pedestrian)</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James J. Brochant</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>6-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>5-5</u>		NAME OF CEMETERY OR CREMATORY <u>Sleepy Hollow Cem.</u>	
LOCATION (City, town, or county) (State) <u>Westchester Co. New York</u>							
DATE REC'D BY LOCAL REG. <u>6/1/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
24. FUNERAL DIRECTOR <u>Robert A. ...</u>				ADDRESS <u>Bethesda, Md.</u>			

561

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04858

4772

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Tabernash Park</u>		<u>10 days</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanatorium Hosp.</u>				STREET ADDRESS (If rural give location) <u>318 Northwest Dr.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Clarence Leon Stewart</u>				<u>5-6-1955</u>			
5. SEX <u>male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>9-27-98</u>	
9. AGE last birthday <u>56</u> yrs		10. MONTHS <u>5</u> DAYS <u>6</u> HOURS <u>19</u> MIN.		11. BIRTHPLACE (State or foreign country): <u>Hawa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>			
13. FATHER'S NAME <u>William Stewart</u>				14. MOTHER'S MAIDEN NAME: <u>Jessie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Acute intra cerebellar hemorrhage</u>						<u>1 1/2 hrs</u>	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION: <u>5/5/55</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Internal hydrocephalus, Generalized atrophy</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-25</u> 19 <u>55</u> to <u>5-6</u> , 1955, that I last saw the deceased alive on <u>5/5</u> , 19 <u>55</u> , and that death occurred at <u>5:40</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Garrett M. Swain</u>				ADDRESS <u>1904 R St. N.W. D.C.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>May 6 1955</u>				REGISTRAR'S SIGNATURE <u>J. William Deeks</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - Transit</u>				NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>			
DATE <u>May 10 1955</u>				LOCATION (City, town, or county) (State) <u>Salina Kansas</u>			
24. FUNERAL DIRECTOR <u>Anna C. Young Lynch, Inc.</u>				ADDRESS <u>—</u>			

4864

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Florida		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X Bethesda Rural		18 days		Key West			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
U. S. Naval Hospital				618 White Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Lawrence Michael SURRENCY				May 25 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: F 3-21-55	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
yrs. 2		Months 4		Days 4		Hours 4 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Florida	
13. FATHER'S NAME: John C. SURRENCY				12. CITIZEN OF WHAT COUNTRY? US			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service) - -				14. MOTHER'S MAIDEN NAME: Gail SWEETING			
15. SOCIAL SECURITY NO - -				17. INFORMANT & ADDRESS: Father John C. SURRENCY CPL USMC Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hydrocephalus, Congenital						2 mos.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Peritonitis & Nephritis						14 days	
19A. DATE OF OPERATION: 5-11-55		19B. MAJOR FINDINGS OF OPERATION: Congenital hydrocephalus				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7 May , 19 55 , to 25 May , 19 55 , that I last saw the deceased alive on 25 May , 19 55 , and that death occurred at 8:55A , M, from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR: W. Mackie				ADDRESS: MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 29 May 1955		NAME OF CEMETERY OR CREMATORY: Private Cemetery		LOCATION (City, town, or county) (State): Key West Florida	
DATE REC'D BY LOCAL REGISTRAR: 26 May 1955		REGISTRAR'S SIGNATURE: W. Mackie		ADDRESS OF FUNERAL HOME: R. A. Humphrey Funeral Home		ADDRESS: 7557 Wisconsin Avenue, Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 1

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100-100000

CERTIFICATE OF DEATH

Reg. Dist. No.

4779

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>22 Bridge St.</i>		STREET ADDRESS (If rural give location) <i>22 Bridge Street.</i>	
3. NAME OF DECEASED: (First) <i>Erna</i> (Middle) <i>A.</i> (Last) <i>Swan</i>		DATE (Month) (Day) (Year) OF DEATH: <i>May 2 1955</i>	
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Jan. 25, 1906</i>
9. AGE last birthday: <i>49</i> yrs		10. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>James Reed</i>		14. MOTHER'S MAIDEN NAME: <i>Agnes Bean</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>	
17. INFORMANT & ADDRESS: <i>Leo L. Swan - Item #2</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Intra-Abdominal</i>		<i>1 year</i>	
ANTECEDENT CAUSE (B) <i>Carcinomatous. 8th.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Undetermined</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>Nov. 1954</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Metastatic nodes. Same undetermined</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov.</i> , 1954, to <i>May 2, 1955</i> , that I last saw the deceased alive on <i>Apr. 29, 1955</i> , and that death occurred at <i>11:14</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Jack H. Harker M.D.</i>		DATE SIGNED <i>May 2, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-5-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/3/55</i>		REGISTRAR'S SIGNATURE <i>Laurel H. Grogan</i>	
FUNERAL DIRECTOR <i>Robert H. Humphrey</i>		ADDRESS <i>Rock, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1944

1944

1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4773

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04861 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Penna.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>17 TOWN Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>75x-3 TOWN York</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>				STREET ADDRESS (If rural, give location) <u>724 W. King St.,</u>			
3. NAME OF DECEASED: (First) <u>John</u>		(Middle) <u>Ziegler</u>		(Last) <u>Sweitzer</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>22</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Separated</u>	8. DATE OF BIRTH: <u>7-5-71</u>	9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William B. Sweitzer</u>				14. MOTHER'S MAIDEN NAME: <u>Lemanda Ziegler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u> </u>		17. INFORMANT & ADDRESS: <u>Hospital Records.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>430.1</u> Immediate cause (a) ... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u> </u> <u> </u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town, (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-22-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bowlers Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Freedom, York Co., Pa.</u>	
DATE REC'D BY LOCAL REGISTRY <u>May 23-1955</u>		REGISTRAR'S SIGNATURE <u>John Dodel</u>		24. FUNERAL DIRECTOR <u>J. Oliver Watts, 254 'Broad St. N.W.</u>		ADDRESS <u> </u>	

RECEIVED
MAY 24 1955
BUREAU OF THE ARMY

4865

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY Arlington	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 26 days		CITY (If outside corporate limits, write RURAL and give nearest town) Arlington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 3234 North Pershing Drive			
3. NAME OF DECEASED: (First) Edward		(Middle) Lee		(Last) TAYLOR II		4. DATE (Month) (Day) (Year) OF DEATH: May 29 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 3-21-97	9. AGE last birthday 58 yrs	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Pilot		10B. KIND OF BUSINESS OR INDUSTRY: Commercial		11. BIRTHPLACE (State or foreign country): Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Edward L. TAYLOR				14. MOTHER'S MAIDEN NAME: Elizabeth SLOAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 057 01 7235		17. INFORMANT & ADDRESS: Son Edward Lee TAYLOR III Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Adeno carcinoma, rectum						30 months	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3 May , 19 55 , to 29 May , 19 55 , that I last saw the deceased alive on 29 May , 19 55 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above.							
SIGNATURE E. J. RUPNIK LT MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland				ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1 June 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 30 May 1955		REGISTRAR'S SIGNATURE Mary E. Cassilly		FUNERAL DIRECTOR'S ADDRESS Chambers Funeral Home 1400 Chapin Street, N.W., Washington, D.C.			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BONNARD V. S.

1895

Wm. H. Bond

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4865

04863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Ind</i>		COUNTY <i>Mont</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <i>Bethesda</i>		<i>S.O.A.</i>		TOWN <i>Rockville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hosp.</i>				STREET ADDRESS (If rural, give location) <i>R.F.D. #2 (Scotland)</i>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<i>Herman</i>		<i>Thomas</i>		<i>May 22</i>		<i>1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	10. UNDER 1 YEAR 11. UNDER 24 HRS.		
<i>male</i>	<i>col</i>	<i>married</i>	<i>Apr. 19, 1929</i>	<i>26</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>habaile</i>				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Henry G. Thomas</i>				<i>Emily Miles</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<i>Flora Thomas 2140 N Street Wash. DC. n.w.</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
982X Immediate cause (a)..... <i>Hemorrhage</i>						<i>few minutes</i>	
Antecedent cause(s) (b)..... <i>Laceration of Rt femoral artery</i>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <i>stab wound at iliac region</i>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>street</i>		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<i>Rockville Mont Md</i>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5-22-55-2:55 A.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>stabbed during an argument</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Samuel J. Bruschait</i>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED <i>5-22-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>5/25/55</i>		NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>		LOCATION (City, town, or county) (State) <i>Rockland Md.</i>	
DATE REC'D BY LOCAL REG. <i>5/25/55</i>		REGISTRAR'S SIGNATURE <i>Samuel J. Bruschait</i>		24. FUNERAL DIRECTOR <i>Robert L. Snowden-Rockville</i>		ADDRESS <i>md</i>	

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12

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04864

4774

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Wheaton, Md</u>	<u>15 days</u>	TOWN <u>Hyattsville</u>	<u>15</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. Hospital</u>		STREET ADDRESS (If rural give location)	<u>1513 Kennedy St.</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Jennie</u>	(Middle) <u>Mae</u>	(Last) <u>Thurman</u>	OF DEATH: <u>5</u> <u>24</u> <u>1955</u>
5. SEX. <u>fe</u>	6. COLOR OR RACE. <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>2-7-1885</u>
9. AGE last birthday <u>80</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Dilley</u>		14. MOTHER'S MAIDEN NAME: <u>Harriett Packey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT & ADDRESS: <u>Daughter, Wash. San. Hosp. records</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE		(A) <u>Intermittent Heart Disease</u>	
ANTECEDENT CAUSE (S)		(B) <u>Generalized Arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/12/49</u> to <u>5/24, 1955</u> that I last saw the deceased alive on <u>5/24, 1955</u> , and that death occurred <u>8:45 A.M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Burtonsville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 25-1955</u>		REGISTER'S SIGNATURE <u>J. McInerney</u>	
24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

RECEIVED V. 2

MAY 1964

REC'D

04865

MARYLAND

4867

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>56</u> TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>57</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>Boswell Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>9110 Wire Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH JANE TIBBETS</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Dec. 27, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year: Months: Days: Hours: Mins.
11. BIRTHPLACE (State or foreign country) <u>Plymouth, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert S. Young</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ellis W. Carnell, 9110 Wire Ave., S. S.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
<u>443X</u> Immediate cause (a) <u>Hypertensive cardiac disease</u>		<u>Broncho pneumonia</u>	<u>several years</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			<u>Two weeks</u>
(c) <u>OTHER SIGNIFICANT CONDITIONS</u> Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1955, to Apr 30, 1955, that I last saw the deceased alive on Apr 30, 1955, and that death occurred at 3:20 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 3, 1955</u>	<u>Rock Creek Cemetery</u>	<u>Washington, D. C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 2/55</u>	<u>James C. Potter</u>	<u>Warner E. Pumphrey</u>	<u>Silver Spring, Md</u>

MARGIN RESERVE FOR BINDING

EDWARD Y. H.

MAY 4 1955

1955

4775

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>17 TOWN Takoma Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>78 Washington San. Hospital</u>	LENGTH OF STAY (in this place) <u>6 1/2 hrs.</u>	STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>16 TOWN Hyattsville</u> STREET ADDRESS (If rural give location) <u>5404 20th Ave.</u>	
3. NAME OF DECEASED: (Type or Print) <u>ALVADA</u> (Middle) <u>Woodrow</u> (Last) <u>Toney</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>May 21 1955</u>	
5. SEX: <u>fe</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>5-28-1876</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>	9. AGE last birthday: <u>77</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>AMELIA Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>amer.</u>	
13. FATHER'S NAME: <u>Robert W. Plippin</u>		14. MOTHER'S MAIDEN NAME: <u>Louisa Ellis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (No) or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>hospital chart</u>		18. MEDICAL CERTIFICATION	
F. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Rupture of Interventricular Sept</u>			
ANTECEDENT CAUSE (B) <u>Myocardial Infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Occlusion</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Atelectasis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/20</u> , 19 <u>55</u> , to <u>5/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>55</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried at Forest Lawn, Richmond, Va.</u>		DATE THEREOF <u>May 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Forest Lawn, Richmond, Va.</u>		LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 21-55</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 24 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 217

4869

1. PLACE OF DEATH

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Boswell Nursing Home
 LENGTH OF STAY (in this place) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia COUNTY Arlington
 CITY (If outside corporate limits, write RURAL and give nearest town) Arlington
 TOWN Arlington
 STREET ADDRESS (If rural give location) 3719 - 25th Rd., North

3 NAME OF DECEASED:

(First) (Middle) (Last)
PAREPA G TRACEY

4. DATE (Month) (Day) (Year)

OF DEATH May 27 1955

5 SEX:

female

6. COLOR OR RACE:

white

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

8. DATE OF BIRTH:

Jan. 22, 1874

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.

81 yrs

10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired):

retired

10B KIND OF BUSINESS OR INDUSTRY:

Housewife

11. BIRTHPLACE (State or foreign country):

Ripley, Ohio

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13 FATHER'S NAME:

Charles Galbreath

14 MOTHER'S MAIDEN NAME:

Eliza Isabell Gaddis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17 INFORMANT & ADDRESS:

John C. Tracey, Arlington, Va.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Cerebral Vascular accident

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

20 days

years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

None

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E INJURY OCCURRED While at work Not while at work

21F HOW DID INJURY OCCUR?

20. AUTOPSY? YES NO

YES NO

22. I hereby certify that I attended the deceased from 9-5, 1955 to 5-27, 1955 that I last saw the deceased

alive on
 SIGNATURE

5-26, 1955

and that death occurred at 5:50 P.M. from the causes and on the date stated above.

ADDRESS

DATE SIGNED

M. D.

23 BURIAL, CREMATION, REMOVAL (SPECIFY)

Shipment & burial

DATE THEREOF

May 27, 1955

NAME OF CEMETERY OR CREMATORY

Elmwood Cemetery

Kansas City, Missouri

DATE REC'D BY LOCAL
 REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Walter E. Humphrey
 Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4269
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868
 Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Silver Spring</u>		<u>5 yrs</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>723 Boundary Ave.</u>				STREET ADDRESS (If rural, give location) <u>723 Boundary Ave.</u>			
3. NAME OF DECEASED: (First) <u>Ella</u>		(Middle) <u>mae</u>		(Last) <u>Villalon</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>3/4/06</u>	
9. AGE last birthday: <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harry W. Ensor</u>				14. MOTHER'S MAIDEN NAME: <u>Edna Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>69-052-0017</u>		17. INFORMANT & ADDRESS: <u>Mr. Pedro G. Villalon, 723 Boundary Ave. Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on kitchen floor</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause <u>777X</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (a) <u>Hemorrhage due to laceration of</u> DUE TO (b) <u>left wrist</u> DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>5-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
DATE REC'D. BY LOCAL REG. <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>Charles C. Trotter</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland</u>	

U. S. A.

4870

CERTIFICATE OF DEATH

Reg. Dist. No. 215...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		1 day		OR TOWN <u>Alexandria</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>U. S. Naval Hospital</u>				<u>Presidential Gardens Apt A-3</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>Baby</u>		<u>Boy</u>		<u>WALSH</u>		<u>May 9 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-9-55</u>			<u>8</u>	<u>36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		
<u>None</u>			<u>None</u>		<u>Bethesda, Maryland</u>		
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>Michael J. WALSH</u>				<u>US</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>No</u> <u>4</u>				<u>- - -</u>		<u>Father Michael J. WALSH</u> <u>Same as above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prematurity at 27 weeks gestation</u>							<u>8 hrs 36 min.</u>
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 1955, to <u>9 May</u> , 1955, that I last saw the deceased alive on <u>9 May</u> , 1955, and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				ADDRESS <u>U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>			
DATE SIGNED <u>13 May 1955</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Complete Cremation</u>		<u>14 May 1955</u>		<u>Prince George Co Crematory</u>		<u>Prince George Co Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>13 May 1955</u>		<u>Mary E. Farrell</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THOMAS A. B.

1880

1880

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4871

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04840

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Roanoke</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Roanoke</u>			
X TOWN <u>Bethesda</u>		<u>118 days</u>		STREET ADDRESS (If rural give location) <u>1211 Mormon Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>1211 Mormon Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
Lelia Dew Webb		May 8 1955		F		W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:		9. AGE last birthday: yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
Married		November 10, 1897		57 yrs. 5 Months 28 Days		Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		-		Virginia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles A. Shaner				Lelia P. Hyman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		Not available		The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
525x IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE (B) 2ndary to renal hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Idiopathic Pulmonary Fibrosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
0 2 0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
None		None		none			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 1955, to May 8, 1955, that I last saw the deceased alive on May 8, 1955, and that death occurred at 11 AM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
William L. Morgan Jr.		The Clinical Center		5/8/55			
M. D. National Institutes of Health							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial-Transit		5-9-55		Roanoke		Roanoke, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
5/9/55		Barrie M. Thompson		Robert A. Humphrey		Bethesda, Md.	

BUREAU V. S.

MAY 1 1911

RECEIVED

4872

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04871

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Fla-</u>	COUNTY <u>Orange</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	LENGTH OF STAY (in this place) <u>2 wks.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winter Park</u>	<u>428-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hospital</u>		STREET ADDRESS (If rural give location) <u>1949 Stanton Ave - 1</u>	
3. NAME OF DECEASED: (Type or Print) <u>Cora Jeannette Wellman</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 14 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 19, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Croftsville, New York, U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ezra E. Snyder</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Peacock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>Miss Thelma Wellman 6604-1st St. N.W. Wash. D.C.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>		<u>2 hours</u>	
ANTECEDENT CAUSE (B) <u>Hypertension, Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>CVA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 29, 1955</u> , to <u>May 14, 1955</u> , that I last saw the deceased alive on <u>May 14</u> , 1955, and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bethesda, D.C. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		REGISTRAR'S SIGNATURE <u>Bernice B. Lawler</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>254 Garrett St. N.W. - Winter Park, Fla.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 23 1955

RECEIVED

4873

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>2 days</u>		<u>Arlington</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>3412 North Vermont Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Jonathon Joseph WEST</u>				<u>May 11 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>5-9-55</u>	
9. AGE last birthday <u>2</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>US</u>		12. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>			
13. FATHER'S NAME: <u>Gordon H. WEST</u>				14. MOTHER'S MAIDEN NAME: <u>Lucille C. O'SULLIVAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>- - -</u>			
17. INFORMANT & ADDRESS: <u>Father LTCOL Gordon H. WEST</u> <u>Same as above</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Sclerema</u>						<u>8 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Prematurity</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 19 <u>55</u> to <u>11 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11 May</u> , 19 <u>55</u> , and that death occurred at <u>5:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Mary E. Allen</u>		ADDRESS <u>M. S. ALLEN LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>16 May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12 May 1955</u>		REGISTRAR'S SIGNATURE <u>Mary E. Allen</u>		24. FUNERAL DIRECTOR <u>R. A. Humphrey</u>		ADDRESS <u>Funeral Home 7557 Wisconsin Avenue, Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. MONTANA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04873

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Bethesda</u>				<input checked="" type="checkbox"/> TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>0007 Elgin Lane</u>				STREET ADDRESS (If rural give location) <u>6607 Elgin Lane</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Sarah</u> (Middle) <u>Whirlow</u> (Last) <u>Whirlow</u>				(Month) <u>May</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Apr 9 1871</u>	
				9. AGE last birthday: <u>84</u> yrs. <u>1</u> Months <u>2</u> Days <u>2</u> Hours <u></u> Min.			
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired. <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Leeds, England</u>	
13. FATHER'S NAME: <u>Samuel Blow</u>				14. MOTHER'S MAIDEN NAME: <u>? Farnsworth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>O.F. Smith-6607 Elgin Lane, Bethesda.</u>	
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Cardiac Failure</u>				<u>approx 24 hrs</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u>							
1.4.9 (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>30 March 1955</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Fracture of neck of Left Femur</u>			
20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>14 Mar. 1955</u> , to <u>11 May 1955</u> , that I last saw the deceased alive on <u>24 Apr. 1955</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Jack W Sanders M.D.</u>				DATE SIGNED <u>11 May 1955</u>			
ADDRESS <u>Cabin John Md</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		<u>May 14-55</u>		<u>Parklawn Cem.</u>		<u>Rockville, Montg. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/12/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 1901

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4875

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04874

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg Rural</u>		LENGTH OF STAY (in this place) <u>5 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>Rural. Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Eugene Wilkerson</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 18 1955</u>			
5. SEX: <u>Male</u>		5. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Nov 30-1954</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Gaithersburg. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Hugh W. Wilkerson</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy L. Selby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Hugh W. Wilkerson. Gaithersburg. Md.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
525X Immediate cause (a) <u>Aspiration gastric contents</u>						<u>1 hour</u>	
Antecedent causes (s) (b) <u>Interstitial Pneumonia</u>						<u>1 day</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1955</u> , to <u>May 18, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Kernan S. Mortens M.D.</u>				ADDRESS <u>Germantown Rd May 18, 1955</u>			
23. BURIAL, CREMATION, REMOVA (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or County) (State)	
<u>Burial</u>		<u>5-20-55</u>		<u>Parklawn</u>		<u>Rockville. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 19-55</u>		<u>Alma L. Gork</u>		<u>Ernest C. Gartner, Gaithersburg. Md.</u>			

20X4191405

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04875

4876

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>--</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>74 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Natl. Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>255 - 12th St. S.E.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Sarah Jane Williams</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>May 3 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>December 1, 1888</u>
9. AGE last birthday: <u>66</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	11. BIRTHPLACE (State or foreign country): <u>South Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Lieutenant Thompson</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of cervix with post-operative</u>			
ANTECEDENT CAUSE (S) DUE TO <u>bowel obstruction and peritonitis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease</u>			
19A. DATE OF OPERATION: <u>4-25-55</u> <u>5-3-55</u>	19B. MAJOR FINDINGS OF OPERATION <u>Stage IV carcinoma of cervix</u> <u>Small bowel obstruction</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>--</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>--</u>	
22. I hereby certify that I attended the deceased from <u>Feb. 18, 1955</u> to <u>May 3, 1955</u> , that I last saw the deceased alive on <u>May 3, 1955</u> , and that death occurred at <u>3:00PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Josher M. Cramer</u>		ADDRESS <u>The Clinical Center</u> M. D. <u>Natl. Institutes of Health</u> DATE SIGNED <u>5-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5-6-55</u>	NAME OF CEMETERY OR CREMATORY <u>Frazier Incl. Home</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Frazier Incl. Home</u>	ADDRESS <u>389 - R - U ave</u> <u>N.W.</u>

U.S. DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
JAN 15 1955

4877

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND			STATE <u>Alabama</u> COUNTY <u>4</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>52 days</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mulga</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>			STREET ADDRESS (If rural give location) <u>Box 225</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Carol R. Wilson</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>May 20 1955</u>		
5. SEX: <u>F</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>			8. DATE OF BIRTH: <u>18 November 1954</u> 9. AGE last birthday: <u>6</u> yrs <u>2</u> months <u>2</u> days <u>0</u> hours <u>0</u> min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		
11. BIRTHPLACE (State or foreign country): <u>Alabama</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Lloyd Wilson</u>			14. MOTHER'S MAIDEN NAME: <u>Annie Watkins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Postoperative shock</u>					
ANTECEDENT CAUSE (S) DUE TO (B) <u>Congenital heart disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO <u>Pulmonary aortic window</u>					
(C) <u>Interatrial septal defect</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>May 19, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Interatrial septal defect; pulmonary aortic window</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>	
22. I hereby certify that I attended the deceased from <u>Mar. 29, 1955</u> , to <u>May 20, 1955</u> that I last saw the deceased alive on <u>May 20, 1955</u> , and that death occurred at <u>5:50a M.</u> from the causes and on the date stated above.					
SIGNATURE <u>George C. Kenser M.D.</u>		ADDRESS <u>The Clinical Center Natl. Institutes of Health</u> DATE SIGNED <u>5/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Interment</u>		DATE THEREOF <u>5-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Sandusky</u> LOCATION (City, town, or county) (State) <u>Alabama</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Beasie M. Thompson</u>		24. FUNERAL DIRECTOR <u>The S. V. News Co</u> ADDRESS <u>2901-14th St NW</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 9 1911

RECEIVED
MAY 9 1911
U. S. DEPT. OF JUSTICE

4873

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>2 yrs</u>	CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	
X TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harold Austin</u>		STREET ADDRESS (If rural give location) <u>8920 Galvin Court</u>	
3. NAME OF DECEASED.		4. DATE (Month) (Day) (Year)	
(First) <u>Harold</u>	(Middle) <u>Austin</u>	(Last) <u>Wood</u>	
(Type or Print)		DATE OF DEATH <u>May 18 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 10, 1885</u>
		9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>M.O.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maine</u>
13. FATHER'S NAME: <u>Jefferson H. Wood</u>		14. MOTHER'S MAIDEN NAME: <u>Conthy P. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT'S ADDRESS: <u>Carl H. Wood 8920 Galvin Court</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) DUE TO <u>E. Bowler</u>			
ANTECEDENT CAUSE (B) DUE TO <u>Cerebral - long bleed</u>			4 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral - long bleed</u>			4 years
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>-</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>5/18/55</u> to <u>5/18</u> , 1955 that I last saw the deceased alive on <u>5/18/55</u> and that death occurred at <u>365P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Richard H. W. M.D.</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>H. Hines Co 2901 14th St. N.W. D.C.</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4879 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04878			
Item 9, FilmG181 5-17-55 et CERTIFICATE OF DEATH			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
Bethesda - Rural	10 Mos. 2 days	Silver Spring	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
U. S. Naval Hospital		927 Northhampton Drive	1
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)		
Bernard Basil WRIGHT	May 4 1955		
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12-8-19
9. AGE last birthday: 35 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner	
11. BIRTHPLACE (State or foreign country): Indiana		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William T. WRIGHT		14. MOTHER'S MAIDEN NAME: Mary NEWLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 220 34 3721	
17. INFORMANT & ADDRESS: Mrs. Dorothy Wright (wife)			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Reticulum Cell Sarcoma			10 months
ANTECEDENT CAUSE (B) with metastasis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2 Aug , 1954, to 4 May , 1955, that I last saw the deceased alive on 4 May , 1955, and that death occurred at 12:55am , from the causes and on the date stated above.			
SIGNATURE M. E. FLIPSE		ADDRESS ICDR, MC, USN	
DATE SIGNED 6-May 1955		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-May 1955	
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR R. A. Pumphrey		ADDRESS Funeral Home 7557 Wisconsin Ave. Beth. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Mary G. Casselley	

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

BUREAU V. S.

MAY 9 1955

RECEIVED

4880

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 417 HILLMOOR DRIVE				STREET ADDRESS (If rural give location) 417 HILLMOOR DRIVE			
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES J. ZELLER				4. DATE (Month) (Day) (Year) OF DEATH: MAY 15 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Sept. 5, 1916	9. AGE last birthday: 38 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: Dept. of Hwys. DC Gov't.		11. BIRTHPLACE (State or foreign country): Grand Junction, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles A. Zeller				14. MOTHER'S MAIDEN NAME: Marie T. Franger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 561-03-9288		17. INFORMANT & ADDRESS: Mrs. Dorothy E. Zeller, 417 Hillmoor Drive Silver Spring, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) Acute Myocardial Infarction		approx 2 hrs.			
ANTECEDENT CAUSE (S):		(B) Arteriosclerotic Heart Disease		3-4 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: none		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 1954, to May 15, 1955 that I last saw the deceased alive on May 15, 1955 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
SIGNATURE Rae H. R. Potter		ADDRESS M. D. 8641 - Colsonville Rd.		DATE SIGNED May 15, 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/18/55		NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		LOCATION Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 5-19-55		REGISTRAR'S SIGNATURE James Potter		24. FUNERAL DIRECTOR Wanner & Humphrey		ADDRESS 8434 Georgia Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.